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ABSTRACT

Reported are proceedings of a conference on drugs and the handicapped child. Provided is the transcript of discussions which centered on the use of legal (prescribed for medical and educational reasons) as well as illegal drugs. Considered are the following major topics: an overview of drug problems in the United States and of drug education in the Rochester (New York) schools; medical aspects and utilization of drugs for learning disabled and hyperactive children; a legal officer/counselor's view of drug utilization and drug abuse; a human development approach to drug education; counseling services at a community center serving high school drug users; methods and materials used in Rochester (New York) drug education classes; instructional methods and resource materials for drug education; values clarification and drug use; educational techniques in drug abuse education; and the peer group approach to drug education. Given are recommendations for an effective drug education program which stressed a mental health approach, peer interaction, and examination of personal value systems. Also included are a basic bibliography of 18 books on affective education, composite results of pre- and posttests by conference participants, and composite evaluation results indicating that most conference participants felt that proceedings were valuable. (LH)

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DRUGS AND THE HANDICAPPED CHILD

Edited by Ken Weiner, 1974

THE UNIVERSITY OF THE STATE OF NEW YORK

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TABLE OF CONTENTS

Title Page

Preface . . . . A

Participants C

Services . . . . F

Program . . . . G

Introductions 1

An Overview of the Drug Scene In Rochester and Surrounding Area
Lou Frasca, City School District 7
Tom Rumsey, Monroe BOCES I 19

Medical Aspects of Drugs and The Handicapped Child
Neal McNabb, MD., Monroe BOCES I 28

Legal Aspects of Drugs and Drug Abuse and The Ramifications of Drug Abuse on Handicapped Children
Joe Picciotti, City School District. 50

A Look At The Human Development Area of Drug Education
Ying Lin, Ph.D., Monroe BOCES I 65

The Center
Peter Essley, The Center 75

Methods and Materials Now Effectively Used In Drug Education Classes
Joyce Porter, City School District 88

Methods and Materials for Drug Education Instruction for Handicapped Children
Marvin Levy, Ph.D., Temple University 107

Values Clarification
Marvin Levy, Ph.D., Temple University 122

Drug Abuse Education: A Pedagogical Schizophrenia
Marvin Levy, Ph.D., Temple University 123

Peer Group Approach to Drug Education
John Lawler, Monticello Central Schools 130

Affective Education: A Basic Bibliography 139

Pre-Post Test 141

Institute Evaluation 144

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INTRODUCTION TO INSTITUTE - JIM MARTILLO

A great deal of gratitude is expressed to the city school system of Rochester, to the Division of Special Education, and in particular, to Mr. Cal Lauder, Bernard Greenberger and Kenneth Weiner. The Bureau for Physically Handicapped Children feels that its dollars were well spent in providing Rochester with the opportunity to host this institute.

The multi-faceted drug problem apparent in our culture today does not have a simple solution. It only stands to reason that difficult problems have difficult solutions. The gestalt of the drug problem today does not begin and end on the street corner, it is not isolated to the ghetto, it doesn't all take place in the lavoratory of the high school, it is not the frustrated mothers in the medicine cabinet. Drug abuse is also evident in the classroom between the physician, the teacher, the principal and the student. One of the greatest abuses of the use of drugs beyond the hypodermic needle in a burned out building is a teacher and the parent and even the principal with a low frustration level appealing to a physician to administer a drug to a child so that he will settle down and learn.

An even greater abuse occurs when there is no evidence of a child's tolerance to the dosage and under the medical rhetoric of adjusting medication, the child is relogated to no less a position than that of a laboratory guinea pig. Admittedly, there may be an unusual case when the need for the scientific application of kemotherapy is warranted. However, take a survey of the number of children in our classes today who are being administered drugs and you will be taken back by amazement at the number of mood levelers being applied. We won't even approach the question of attempting to accept the child as he is or building his self-image nor will we approach the problem of a teacher, a parent and a principal with such a poor self-concept that they become threatened by a seven year-old child.

Instead, we will try and continue our focus on the small developing mind and body in which foreign substances are continuously induced in order to bring love and harmony to a situation which, in reality, is no more than a professional fleeing fantasy.

Reinterating what was said earlier, there is no easy solution to a difficult problem. So again, I won't even begin to suggest one. However, I will suggest this. If you, as a teacher and an educator, think you are not part of the solution then you are definitely part of the problem.

I can talk about L.S.D., peyote, mescaline, or heroin in relationship to terms such as euphoria, nausea or lethargy. They are illegal drugs. But in reality, don't the same side effects occur in a seven year-old child for which we find medical and educational reasons to induce these foreign substances

In conclusion, we must be forced to take a look at ourselves as teachers and educators. We may have come to a point where we think we know it all. We have bceme very wise. However, it is precisely at this point, when we think we have all the answers that we should stop and take a good hard look at what we are doing.

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The inducement of drugs into the student will not solve a problem, it is not the conclusion, it is not the answer. Many of the greatest minds of history have gotten caught in this trap of wanting to solve difficult problems with simple solutions. As teachers and educators we must take care that we do not view mood levelers as the ultimate power and answer for a child with behavioral problems in a classroom. Maybe an alternative attempt to change the mood of the child would be an attempt to change our own disposition, our own outlook, our own attitude.

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Technical and Electronic

Jim Rauber

Fri. cont.

6:30 Dinner

7:30 Session

Film: Brian at 17

8:30 Group Sessions

Methods and Materials Now Effectively Used in Drug Education Classes.

Mrs. Joyce Porter and
Mrs. Annette Schaff,
Specialists, Drug Education,
City School District

SATURDAY, June 2, 1973

9:00 Session

Methods and Materials for Drug Education Instruction for Handicapped Children.

Dr. Marvin Levy,
Chairman, Health Education
Department, Temple Univ.

10:30 Coffee

Group Sessions

12:30 Lunch

1:30 Group Sessions

2:30 Coffee

4:00 Evaluations

Closing Remarks

PLANNING COMMITTEE

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City School District
Rochester, New York

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Assistant Director
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The State Education Department
Division for Handicapped Children
Bureau for Physically Handicapped
Children

In Cooperation With

The
Department of Special Education
City School District
Rochester, New York

Presents

"DRUGS AND THE

HANDICAPPED CHILD"

May 31, June 1,2, 1973

Foreman Center
41 O'Connor Road
Fairport, New York

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Special Studies Institute
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INSTITUTE SCHEDULE
THURSDAY, May 31, 1973

INSTITUTE DIRECTOR

Ken Weiner
Director, SEIMC
Department of Special Education
City School District
Rochester, New York

ACKNOWLEDGEMENTS

New York State Education Department
Division for Handicapped Children
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  Assistant Director

Bureau for Physically Handicapped Children
  Richard Hehir, Chief
  James Marillo, Associate

Dr. John Franco
Superintendent of Schools
City School District
Rochester, New York

Dr. Kenneth Harris
District Superintendent
First Supervisory District
Monroe County

Mr. Calvin Lauder
Supervising Director
Department of Special Education
City School District
Rochester, New York

4:30 Greetings

Mr. Ken Weiner,
Institute Director

Mr. James Marillo, Associate,
Bureau for Physically
Handicapped Children

Mr. Gary Barr,
Assistant Superintendent,
Monroe BOCES #1

Mr. Frank Tota,
Assistant Superintendent,
Division of Instruction,
City School District of
Rochester

Mr. Cal Lauder,
Supervising Director,
Special Education, City
School District of Rochester

5:00 Session

An overview of the Drug Scene in Rochester and surrounding areas.

Mr. Louis Frasca,
Supervisor, Drug Education,
City School District of
Rochester

Mr. Tom Rumsey,
Coordinator, Drug Education,
Monroe BOCES #1

6:30 Dinner

Thurs. cont.

7:30 Session

Medical Aspects of Drugs and the Handicapped Child

Dr. Neal McNabb,
Pediatrician, Deputy
Director, Clinical Monroe
Developmental Services

8:30 Session

Legal Aspects of Drugs and Drug Abuse and the Ramifications of Drug Abuse on Handicapped Children.

Mr. Joe Pocciotti,
Specialist, Drug Educatic
City School District

FRIDAY, June 1, 1973

4:30 Session

A Look At the Human Development Area of Drug Education.

Dr. Ying Lin,
Psychologist, Monroe
BOCES #1

5:30 Session

The Center

Mr. Peter Essley,
Director

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THURSDAY, MAY 31 - EVENING SESSION

Ken Weiner

Welcome. My name is Ken Weiner. I'm the one that sent you all sorts of information to get you here.

First thing on the agenda is the inevitable change. The way things were originally scheduled, Mr. Frasca and Mr. Rumsey were going to speak to you prior to dinner, but since the dinner is so exceptional tonite, they have asked to move the dinner forward a half hour to six o'clock. We're going to rearrange slightly and Mr. Frasca will speak; then dinner, then Mr. Rumsey. So, in the chain of events according to your program that's the way it's going to work for tonite. All those of you who are really hungry, I'm sure are very pleased to hear that.

I'd like to say a couple of things on behalf of the State Education Department. Jim Marillo who was supposed to be here all three days was told by the Commissioner that he would have to represent the State Education Department in New York City, where they have had a problem. He has been there a week and will be there three more. There is a suit of some sort happening in New York City and his responsibilities will have to be there. He called today and regrets very, very much that he couldn't be here to go through this workshop. He told me that from the workshops the State Education Department has run that this looked like it was going to be one of the most interesting and that he was sorry that he could not attend.

On behalf of Jim Marillo and Richard Hehir, the Chief of the Bureau of the Physically Handicapped Children, I wish to welcome you here

Ken Weiner

tonite, and hope you have a very interesting and informative institute.

Mr. Gary Barr, the Assistant Superintendent of BOCES I is here to say a few words of welcome to you. Mr. Barr...

Gary Barr

Thanks Ken. Words of Welcome often take alot of valuable time from what your real purposes are so I'll be brief. I simply would like to say that we at the Foreman Center are particularly interested in your topic and that interest is displayed in two ways. The fact that you're here and we welcome you to the facility is one. We like to brag a little about it, you're going to have dinner in our gourmet cafeteria. Be hungry it's terrific and we're proud of it and we're glad you can take advantage of it.

We're desparately interested in the handicapped child and like all others working with the full range of children, pre-school to twenty-one, we have our concerns about Drug Education, drugs, their use, etc. I'm quite pleased to see three members of our staff on your program and I'll embarrass them by mentioning them, but I think that shows we are interested too. Tom Rumsey, Dr. Lin and our Consulting Pediatrician, Dr. Neal McNabb. I also see some other very impressive people on your program. I'm sure you're in for a wonderful workshop. As I said to Ken, any group that would come out to a workshop in Rochester on the first nice day in seven weeks has to be dedicated. He assured me that we have had three hours of sunshine and that was the quota for the month. I hope he's wrong.

Welcome, have a good workshop and it's a real pleasure to have you with us. Thank you.

Ken Weiner

Thanks Gary. The next person to welcome you also got caught

Ken Weiner

up in a meeting this afternoon. Mr. Frank Tota, who is the Assistant Superintendent for the City School District, Division of Instruction. In his stead and also representing himself and the Department of Special Education of the City School District I would now like to present to you someone who probably most of you already know, Mr. Cal Lauder.

Cal Lauder

Thanks Ken. By the way Ken, with that kind of advertisement for food, I think I can stay for dinner. In spite of the weather. I just left a meeting with Mr. Tota from the Division of Instruction dealing with a group who represent Urban Funded Programs and other community groups. I will pass on his apologies with this added comment. I'm just as pleased that he is with that group and I was able to leave the meeting and come with this group.

I would like to, on behalf of the Division of Instruction and the Department of Special Education in the City, welcome you to your workshop this afternoon.

So often and most usually as we look at handicapped kids I think one of the things that comes to our mind is the fact that this is a group for the most part that does not have options. They come to us with problems that do not have the option to develop in a manner in which they develop. There is a minimum of options as to the way we manage them, the system we establish, the educational program or the counseling program or the system is developed around them. To frequently it includes the lack of options of being involved, except for a few kids who might be in special educational programs that we have main streamed, they don't have the benefit of some of the kinds of services that are necessary that other kids have.

It reminds me a little bit, speaking of options, of a wedding

Cal Lauder

reception, where the hostess had her line coming through and she was pouring punch for the group. She was a little concerned because she only had one punch bowl and there was alcohol in the punch. So she decided, "Well I'll alert everybody that comes through that there's alcohol in the punch". A young fellow came through, poured his punch, and she whispered in his ear, "There's alcohol in the punch." The fellow got his glass and filled it to the brim, and said, "This is a great party, I'm glad I was able to come, and I'm really pleased that we are having this kind of punch." Following him, however, was a minister and as the hostess started to pour, she whispered to the minister, "Sir, you should be aware that there's alcohol in the punch." Well, the minister straightened himself up and said, "Ma'am, I'd rather commit adultry than drink alcoholic beverages." At that point the young fellow in front turns around and starts emptying his glass into the punch bowl. The hostess said, "What are you doing?" He said, "Well really, I didn't know we had a choice."

I think we have to take some initiatives relative to options. That's one of the things we certainly have too do for kids with certain kinds of involvements or any kind of involvement. We have a responsibility to see that they receive no less. The legislation which was considered last week relative to equal opportunity for the handicapped, a spin off of the Pennsylvania legislation, I think gives us direction. I think in the future, we must certainly fulfill our obligations to kids regardless of their needs or their problems. I would hope that this afternoon you take a position of developing options that are preventative in nature, remedial in nature and take some initiative which is certainly going to be one of the out comes of input here at this institute. It was just about a year ago when I met with some of the staff of the State Education Department and we decided one

Cal Lauder

of the priorities for institutes around the state would be for the handicapped in drugs and drug education. We just cant' exclude the kind of kids that we have responsibilities for from some of the ideas of the main stream because our kids have the same needs. I know you're going to have a profitable afternoon and evening. My suggestion is, however, the input, I was going to use another analogy but I don't think I will, if it is'nt carried away from here, and kids aren't the recipient, then we haven't done our chore. As participants or as leaders for the workshop, or as people moving this kind of force ahead, the responsibility is yours to take it from here. You'll get it this afternoon, just take it and run with the ball. Thank you.

Ken Weiner

A couple of months ago when we first really got into this institute, a group of us, myself, teachers, and a psychologist sat down and tried to work out where we ought to go, what direction we should take. In going to any institute, if any of you have ever gone to an institute or workshop, and I'm sure you have, I think that the key is relevance. If it isn't something, as Cal said, that you can grab ahold of, take it and go back to a classroom and work with children, you really haven't gotten anything. We decided that beyond the state mandate, beyond the three areas that the state specifically asked us to cover, we would ask you people what is it that you wanted and then tried to satisfy those requests. At the end of this program you will be able to evaluate our efforts and tell us if this is, in fact, what we did.

The state wanted us to inform you of things concerning the medical aspects of drugs, and drug abuse. They wanted us to talk to you in terms of the legal aspects of drugs and drug abuse. The third mandate was the educational aspect. Now that you know what is and what isn't legal, now that you know what is and what isn't, medically speaking,

Ken Weiner

now, what do you do about it. How do you approach these children, the handicapped, and work with them in those areas. We felt that probably the best way to proceed would be to give you first an overview. What is the situation with drugs in the areas in which we live, with the children we see in school. Then after we have a general picture let's take a good close look at what the ramifications are both medically and legally. With all that knowledge and background we'll go into the educational aspect. We'll build until we get to what things are available to us, what materials are available to us, what are the ideas that have been tried and failed, what are the ideas that have been tried and succeeded.

With that vein in mind we embarked upon this institute and the program which you are about to get into.

With each speaker we have left plenty of leaway, as far as time is concerned, for you to ask questions. No speaker is so perfect that he can answer every question of every person he is talking to. I would hope that since you did come out on this beautiful evening that you will not let a question in your mind go unanswered, that you will speak up and ask questions to get experts answers.

Lou Frasca began working in the field of drugs and drug education in 1953. He was appointed the Director of The Council on Alcoholism for Rochester and Monroe County. Since then he has been a health education teacher, coordinator, science teacher and guidance counselor. He has been the Executive Director of the Ontario County Narcotics Guidance Council since its inception three years ago. He is currently the Supervisor of the Drug Education Program in the City School District of Rochester. This is a K-12 program employing mental health concepts through the use of group dynamics.

Mr. Frasca is going to kick us off tonite by giving us an overview

Ken Weiner

of the drug scene in this area. Mr. Frasca...

Lou Frasca

Thanks Ken. As Ken already has stated I would like to share with you an overview of what I think the drug concern problems are in this country. The second thing I would like to deal with is what is drug education in schools.

We need to start by mentioning that I don't think we'll get anywhere with drug education in schools unless we can involve parents, teachers and students. I feel it's necessary to do this. I think that programs have failed because of a lack of involvement.

People in general are very unkowledgeable regarding the drug scene in the United States. They're very unknowledgeable regarding drugs. An illustration is that people don't consider alcohol a drug.

Let me elaborate on some of my concerns. First of all we are a drug oriented society. We have been as far back as this country has existed.

Previous to 1971, eight billion amphetamines were produced by pharmaceutical companies in the United States. Of the eight billion, four billion ended up on the streets. A large number of them went into Mexico and were routed back into the United States as a street drug. Amphetamines, as a number of you know, are the uppers, the stimulant drugs. There are a variety of them, about twenty currently on the market. Dexidrene, Bensodrene, Methadrene, are some times called speed in the street slang. They are also better known to adults as the diet pills. In 1971, through the efforts of the Bureau of Narcotics and Dangerous Drugs, there were restrictions placed on the manufacture of amphetamines and currently there has been a reduction from the eight billion. Eighty two per cent less are being manufactured today. You may think that's great. On the surface it does sound great.

Lou Frasca

Unfortunately, as we cut down on the manufacture of amphetamines by pharmaseutical companies, people simply are making their own. The compounding and synthesis of the drug is very simple. We end up with bootleg amphetamines to take up the slack on the street. We don't solve problems easily by prohibition. I think it needs to be said that amphetamines are very definitely a drug of abuse. There are too many medical authorities who believe that there are only two legitamate reasons for prescribing amphetamines. Those two reasons are for narcoepsy which is, in medical dictionary, "a rare malidy, inability to remain awake". The incidence of it is very small. Tonight we have a physician and if someone wishes to mention narcoepsy for his reaction you might do so. The second reason for prescribing amphetamines according to a number of physicians, is hypertension, which is a condition where young children are hyperactive, very over active. I'm sure that you have had some of these children as students. Somehow, somewhere, they learned that if you gave these children amphetamines instead of making a hyperactive person a super hyperactive person, it did the reverse, if slowed them down. These then are the two legitamate reasons for prescribing amphetamines according to a number of medical people. One who has agreed with this consideration is Dr. Atkins who I heard speak three years ago. At that time, before the ban on producing amphetamines reduced the production 82%, he said that he felt because of the legitamate reasons for prescribing this drug the production of amphetamines in the United States should be banned.

The next point that we need to discuss are the barbituates, the downers, the sleeping tablets. They are Seconal, Demotal, Phenobaritol, ect. The physician prescribes this drug as he does the amphetamines. Many people believe that this drug is prescribed all to freely and as a result of it, it's a drug of abuse. It's on the streets as a down drug.

There are a number of problem with this particular drug as a result of the fact that their availability on the street is very easy. When they first came out they were not supposed to be an addicting drug and we have learned since they came onthe market that they are highly addictive, physically addictive, and there are overdose deaths as a result. Four to six billion barbituates have been prescribed and here again, no justifiable reason in the eyes of many people for that number of prescriptions.

Another illustration of the fact that we are a drug society can be seen when we take a look at the two most prescribed drugs in the United States. They are the minor tranquilizers librium and valium. I'm sure a number of you have had these and maybe legitimately, but very, very frequently, they are prescribed freely by physicians or demanded too frequently by the patient.

They we come to the granddaddy of the drugs of abuse, alcohol. Alcohol is the most used and abused drug in our society among youth and adults. Seventy percent of our adult population uses alcohol. A lot of people make a big to do about pot. Pot is second with young people to alcohol. I've seen the results of some 35 surveys and without exception, alcohol was always number one. We never give that much concern to alcohol and yet I think it would not be at all difficult to establish absolute evidence that it's the most devastating drug in our society. There are fifty-five thousand people killed on the highways each year. Over half of these people are killed in highway auto accidents as a result of being under the influence of alcohol. If we take a look at the addictive concern of alcohol we see that out of seventy million adults who drink alcohol in the United States nine million are alcoholics. They are compulsive drinkers and they are addicted to alcohol much like the heroin addict is addicted to heroin. One person in sixteen who drinks alcohol is addicted. We don't seem to give much concern to it as we look at the drug scene. Until 1920, alcohol was legal, and then came prohibition. From 1920 to 1932 we had that roaring era that a number of us know about and others have read about. Young people talk about the prohibition of pot. The new prohibition, I don't think that we are facing reality as we look at the use of marijuana in out society. I'm not saying to legalize marijuana. We're not dealing properly with it. The case we can make against alcohol could go on and on. The point I'm trying to make here in regards to alcohol is that I like to compare alcohol with marijuana. It has a number of parallels, prohibition is one. Alcohol is an intoxicant as marijuana is an intoxicant. I think this is something that people should take a close look at as they look at the drug problem.

We continue with our drug society when we take a look at the use of cigarettes in our society. I don't know how many cigarettes you have to smoke a day until you are hooked. We have people who are psychologically addicted. If you are using cigarettes and you can't stop, you have a problem. You're hooked. And yet you know what's on the pack of cigarettes. "Beware, the Surgeon General has determined that cigarette smoking is dangerous to your health." Twenty years ago the American Cancer Society was saying that kind of thing. They didn't have the documentation twenty years ago. You know people who don't smoke cigarettes have less lung cancer than people who smoke two packs a day.

I'd like to read to you some excerpts from a Congressional Senate hearing in 1971. It points out more vividly than I have done to this point that we are a drug society and we need to be concerned about it. The Senate Hearing in 1971 dealt with mood drugs, sedatives, tranquilize and stimulants.

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Lou Frasca

Dr. Donald Lauria in answer to questions from Senator Nelson stated. . . . .

> Let no one delude himself into thinking there is no comparison between excessive self-medication and the use of illegal drugs. Good studies show that parents who use inordinate amounts of medicines create children who have a far better likelihood for using illicit drugs. Parents who use legal drugs have children, by three independent studies, who use illegal drugs in large numbers. There are three studies worth quoting. One is by Malone, the second was done by Dr. Smart in Canada, and the third is our study which was done in New Jersey. I deliberately selected data from each study rather than to impose on you the enormous number of statistics. In Malone's study if you look at intensive users of amphetamines, that is, regular amphetamine users among the young, thirty-one percent of their parents use stimulents ie. amphetamines. For less extensive users the figure was nineteen percent, whereas the non-users had parents who used amphetamines five percent of the time. I think that you can draw a very solid correlation to establish the fact that parents who use drugs have children who use drugs. That is, among the extensive users, there was a six fold difference in the likelihood that their parents would also be an amphetamine user. In regard to tranquilizers among the intensive users among the young, the parents use tranquilizers in 68% of the cases, less intensive users 55%, and among the non-users 38% had used tranquilizers. Here again is a correlation pointing to parent drug use, youth drug use. So once again if a young person uses tranquilizers the chances are far greater that the pattern was established previously within the household. I think at this point I'd like to say for your consideration that young people did not create the drug scene they inherited it, from the adult society.
>
> I think that Dr. Smart's study in Canada we found that if the mother is a daily tranquilizer user that a child is 3½ times as likely to use marijuana, 10 times as likely to use heroin, 5 times as likely to use a stimulent or LSD, 7 times as likely to use tranquilizers as the appropriate control group whose mothers were not daily tranquilizer users. Here again studies bare the fact that children have parents who use drugs if they are using drugs. If a mother uses tranquilizers daily 35.9% of this series of children use marijuana as contrast to 9.7% parents in a control group. That's a very substantial difference from 39% to 9%.

Herein lies our problem when we look at drug education. Who is it we need to educate? Children? Parents? Teachers?

Lou Frasca

Ken said that we look at drug education by taking a mental health approach. It seems to me that it is the only thing that makes sense. There are three precepts in mental health. They are (1) how you feel about yourself (2) how you feel about others and (3) how you feel about life's problems and stresses. If people can deal positively with self, self-image, if they can deal well in good inter-personal relations and if they can handle stress and cope with life problems positively then the likelihood these people will abuse drugs is not very large. I did say abuse not use. In the Rochester City School District the drug education staff feels that you must use a mental health approach. You deal with these three concerns in a group counseling situation where the group leader is trained in counseling and knows how to work with the group. Then many positive things happen.

One of the things needed in dealing with groups is that the teacher or the counselor, dealing in drug education, must establish trust with the students. There must be a trust established between students. A peer interaction trust. Then there's a lot of free flow of ideas. When you deal in this climate decision making becomes dealing in value clarification. What are the values? How do you deal your values? Are you really dealing with your values or haven't you given that much thought to them? This creates positive drug education.

A number of us believe that drug education really is a misnomer. It's really education in living. It is the affective domain and not so much the cognitive. I think that idealistically drug education is a blending of something cognitive with the affective concerns of individuals. Unfortunately, until recent years we haven't had much to help us to deal with drug education. You have to give them information relevant to their age level and appropriate to their cultural background.

Why do young people use drugs? We have to help them reinforce their positions within themselves and with peer pressure. We have to help them establish their position to curtail curiousity concerning drug use. Here then are two reasons why young people use drugs. Peer pressure, curio sity, and simple experimentation which is a natural process within all of us and certainly among young people. Cognitive learning is not very important in drug education. Studies have pointed out that youthful drug users know more facts about drugs than the kids who don't use drugs. Certainly there is no correlation between drug knowledge and limiting drug use. The other concern we have regarding drug knowledge is that so much of the information being disseminated is misinformation. This has created a problem for teachers. That which is called "credibility gap". If you say things about marijuana that are not true the kids know it isn't true so wont believe what you say about heroin or L.S.D. I think we need to be concerned. Our problem in this area is that not many people know very much about drugs. The information disseminated in many schools by many people, teachers or whomever, are not giving kids facts. This is a serious error. I'd like to quote from Upstate Teachers December issue. "You can trust most contemporary pieces of drug information to be valid and relevant about as much as you can trust the drugs sold by your friendly street pusher to be potent, safe and unadulterated. Of the 220 educational films 80% contain scientific and medical misstatements about drugs and drug effects. Only 16% of the films have been found to be scientifically acceptable. 31% were considered totally unexceptable because they were inaccurate. distorted and unsound. 53% were classified restricted, requiring special care in the presentation."

This is a very serious problem in drug education programs in schools. All kinds of people use all kinds of educational audio visual materials that aren't much good. We can do a lot of harm with these films. We in the Rochester City School District own 35 of these films and our staff is using practically none of them. We've had a great deal of growth during the two years we have been funded through the New York State Narcotics Addiction Control Commission. Our research also shows that the most popular films in schools comes from .this objectional list of films.

> "A teacher who shows one of the unexceptable or restricted films will seriously harm any effort to present an effective drug abuse message. The majority of the 220 films are unfit teaching aids and a disservice to the classroom teacher. Much money is being wasted on poor materials and misinformation".

There are literally mountains and mountains of materials. Too, now I am frightened. Everyone wants materials. Everyone wants to show a film. Further the misinformation has become so serious and widespread that plans are now under way to declare a national moratorium a production and distribution of new materials. We must get rid of the existing misinformation and use only new materials that are valid.

Our concern then, in drug education, is dealing with knowledge. Unfortunately most of us don't have the knowledge and we are imparting incorrect information to the kids. More importantly is the way of drug use. That is the effective concern. In conclusion, drug education is a misnomer. It really should be a course in living. We must realize that in order to work effectively in drug education we have to deal with affective domain.

Lou Frasca

Can I react to any questions? There are a number of challenging things said. Anyone?

Participant: The point that you brought up about correlation between parents using drugs and the incidence of their children using drugs, I'm wondering if the possibility exists that if parents do, and I'm sure a lot of people here take some form of a prescribed drug, if we explained the drug we are taking and the purpose for using the drug when we are taking the drug, wouldn't it take away some of the mystique attached to drug taking? If you have to take a drug and your young son or daughter watches you slip something into your mounth you could explain what the drug is and what is wrong with you and why you have to take it rather than leave the mystique.

Mr. Frasca: It makes sense to me. Of course when we talk about amphetamines and drugs of abuse, there really aren't any valid reasons for the four billion amphetamines that had been taken previous to or in the first part of 1971. Yes, but I think sometimes parents would be very hard pressed to justify their drug uses.

Participant: I think one of the points that was brought up was general abuse of drugs with the fact that if the parents are using these particular types of drugs, amphetamines, tranquilizers, etc., that your children are more likely to use these same forms and maybe other drugs. Another problem I start to wonder about is that it's not the simple mechanics of taking these drugs, but rather the need of taking these types of mood changing drugs. If this is the mood within a family, the parents need it, it would follow their children are in that environment.

Mr. Frasca: They may very well.

Participant: So they are coping.

Mr. Frasca: You have to deal with that and that's one of the dilemas of it all isn't it? It may very well be that they are the children of the parent who has a personality problem the child may have also.

Participant: For example you get upset, you take a drink, you need to relax. Using alcohol is the most popular because it is the most acceptable.

Mr. Frasca: And the most used.

Participant: And the most used, right. I need a cigarette because I'm nervous. Over a period of time these are ideas that are transferred to the children.

Mr. Frasca: My response to that to parent groups from time to time has been something very simple. Adults need to do an inventory of where they are in the drug scene. How you deal with it is up to you, as an individual, as a parent. Where are you in the drug scene? If there are studies that point to the fact that parents who use drugs have children who use drugs in very large numbers then you as a parent have to deal with it. How are you going to? It's a challenge. We are a drug society and it doesn't seem we are doing much about it.

Participant: Have there been any studies looking at the effects of mass media advertising on society as a whole?

Mr. Frasca: They are concerned about it but what they are going to do about it I dont know. What about 3 or 4 years ago when the advertisement of cigarettes on television was eliminated. That didn't in any way deter cigarette smoking among adults or youth.

Participant: I'm not really asking you if taking advertising off television would change society's attitude. Maybe what I'm questioning is how does our television advertising effect youth? Does it help create the drug society?

Mr. Frasca: I think it tends to perpetuate it, don't you?

Participant: No.

Mr. Frasca: I would think so.

Participant: What is the alternative?

Mr. Frasca: What are the alternatives? We are a drug society and we have to do something about our values. We as adults have to do something about drug use. We have to do something about the value system in which we live. I think these are some of our problems. Our solutions lie in restructuring our society. There is another concern, another solution we have to be concerned about. Values. This is why I think value clarification helps young people to establish values. But if they, in a sense, inherit the values of their parents, they also inherit the drug use.

Participant: You were talking about doctors prescribing diet medicine. Have amphetamines been as easy to get as over the counter drugs? Are over the counter drugs harmful?

Mr. Frasca: There are many dangerous over the counter drugs. I think it might be a question you might ask the physician this evening. I think very seriously we need to do something about regulating drugs in our society. Not only the prescription drugs. I think there's probably very sizeable abuse of a number of the patient drugs and the over the counter drugs. Will our society permit it? Will the pharmaceutical companies fight it? Will the physicians cooperate?

Participant: I'm sure you have concern with the effect of parents taking drugs and kids taking drugs. Is it not important to look at other things such as the media or peer groups without placing overdo emphasis on parents?

Mr. Frasca: I don't object to that. Certainly the abuse of drugs is multi-caused. Can you think of some other reasons why we have this drug problem?

Participant: We mentioned peer pressure.

Mr. Frasca: Studies point this out as being one, two, three. (1) Peer pressure. (2) Curiosity. What is it like to be stoned? What is it like to trip? (3) Simply experimentation. Another which is number four in a Monroe County survey that all the school districts took part in two years ago is psychological needs.

Participant: You introduced the idea that if parents use, kids use. I was wondering if you have any information on the handicapped child who is currently on medication such as ritalin, or other drugs, are prone to drug abuse. If so why should they be more prone?

Mr. Frasca: You have a physician tonight and I hope that he would deal with that topic.

Participant: I would like to ask you two questions. Number one, How do you see Rochester's problem in city schools?

Mr. Frasca: Do you mean the Rochester schools, Rochester?

Participant: And more specifically, how do you see the incidence as it pertains to schools?

Mr. Frasca: In answer to your first question, a lot of people sit in the suburbs thinking that they don't have a drug problem. Of the study in Monroe County which was done county wide to include all of the schools pointed out that there was a very, very high correlation between city drug use and the schools in the suburbs. Almost a, I think it's called a plus one correlation, 7.8 percent using in the city, 6.9 in the county, as we dealt with various drugs of abuse or street drugs. The exception to that was heroin. There was a 33 percent greater incidence of use of heroin, according to this survey, in the city than county and that would make sense. Heroin has some cultural implications. Your second question.

Participant: What is the problem?

Mr. Frasca: We have a study, I have a copy of it with me. I'll let you see it. We have dissemination. I don't know whether this is good or bad.

Participant: Just answer that one specifically. What's the incidence in the schools?

Mr. Frasca: I don't know. But I have a feeling that handicapped children who are on medication and have certain concerns and problems make them more susceptible to drug use than non-handicapped people. I have that impression. If you press me to validate it, I couldn't.

Participant: This just doesn't come from the home, this is also being pushed in school. The boy always wanted to be a fireman or a policeman. Now teachers in the classroom situation are pushing him to be a scientist, a doctor, or president of some corporation. Don't you think this is some of the problems of pressures? These kids are being pressured at a very early age. It's hard to become a president, earn a lot of money, and have a big house. I think that values have been changed. We feel that the more money we make, the happier we will be. This is just mixed up.

Mr. Frasca: I think this goes back to the gentlemen who's looking for other reasons, multi-cause. Seems to me if values and a family are in conflict, this would cause frustration. If there is frustration, there will be drug abuse.

Ken Weiner: If anybody has any other questions of Lou you can corner him when we break for dinner. I'm sure he'll be glad to give you any answers that he has. I told you we were going to bring Tom Runsey on after dinner but there's one little section of his presentation that must go on before we break for dinner because we have a couple of young men who came over from Rush-Henrietta to speak to you and answer some of your questions about a program. I'll let Tom introduce them.

Tom Rumsey: I'd like to introduce Gene Collacki who's Coordinator of health and drug education in the Rush-Henrietta school district.

I asked him to come here because he has a different type of drug education program than most schools. I'll let him explain it to you and I'll let him introduce his guests to you. By asking them questions, I'm sure you'll get a feel of how effective his program is. Gene......

Gene Collacki: This is the type of program we feel is still in the experimental stage. Never-the-less we have found that it is very successful. I like to call this, Project Early Approach. This is a peer group approach to teaching about drug use and abuse. This is where we train sophomores, juniors and seniors at the high school level and they go down into the elementary schools. Last year we started at the sixth grade and this year we are currently in the fourth, fifth, and sixth grades. We would like to try to go up to Junior High School but we do not have enough volunteers.

Now these people are selected from the health education classes or teachers recommended them. From there we have a screening committee who asks the students questions and from that we select. In this group we had about forty students. From that forty students wehave had about half go out into our school district. Our school district is comprised of eight elementary schools, three junior highs, and one senior high. Our training program consisted of twelve sessions of one hour each. We try to break the program up into various aspects. For example, we have one aspect just dealing with the pharmaceutical aspects. We get another dealing with methods and materials in drug education. We had this project in conjunction with the Narcotics Guidance Counsel in Rush-Henrietta. Not everybody profited by the sessions. But those that did go into it have a better insight. I think I will just cut it off here and introduce two of the students that have gone to the various schools within the district. We have Marsh Rich, a sophomore, and Kip Webster who is also a sophomore.

Most of our people are either juniors and seniors. If you have any questions that you would like to direct to them, this would be a good opportunity to ask about the advantages or the disadvantages of the program.

Student: If there are any questions just shout them out.

Participant: I'm interested in why you fellows got involved with this program. What were your motivations?

Student: I just heard about it through my friends. My first reason was because I was getting out of classes. I'm in the Narcotics Guidance Counsel like Mr. Collacki. I just like to do it. I've got a sister in sixth grade and two brothers in fourth grade. I just felt like doing it so I did.

Participant: When you go into a classroom how do you begin? Do you start with an open session.

Student: In our school we started out with a question and answer period. We just got to know the kids for about two sessions. After that it went into whatever the kids wanted to do. I asked them, would you like to do a play or role playing? I let them make it up. It was funny. They all made up a play where in the end the kid would die. It never turned out any other way. The kid used drugs and he died and that was that. In two out of three classes we did plays and the other class just had questions and answers. One of the bad things about questions and answers is that the kids always seem to direct personal questions to you which sometimes put you on the spot.

Participant: Like, are you straight?

Student: More like did you ever use LSD? You have to be truthful with them. Some of my friends have done it. Not a lot. I just was truthful with them and told them what happens. That's just one bad point about it. The kids trust you because you're truthful with them.

That's a reason why it does work.

Participant: How do the students respond to you?

Student: They seem to like us. Next year they'll be going to junior high. They're really interested about what's going to happen because they'll be traveling from class to class. They get five minutes in the halls. They're pretty excited about that.

Participant: I think I read a letter to the editor.. He received a complaint about a lack of information.

Student: You'll have to ask Mr. Collacki. I've never seen anything like that.

Collacki: That was a stupid thing that woman wrote. She blew it all out of proportion. Now, if she would have called my office, I'm certain I could have straightened it all out. Sometimes it takes just one person like that to trigger off something.

Participant: What kind of reaction have you gotten from your classmates?

Student: Noone seems to be aware of the program. Just a few personal friends that I know. You don't walk around the hall and hear them say, "there's that kid that goes and teaches the little kids about drugs". It's not like that. No peer pressure.

Participant: Do you believe that you're being truthful when discussing this?

Student: The kids are being truthful.

Participant: Are you being truthful in developing a program of this kind? You must discuss its usefulness. They might think why they need it.

Student: I think some of it has discouraged them.

Participant: If they find out that they're not going to die then they're not going to be afraid any more. Has it cured some of the experiments?

Student: With Fifth and sixth graders it's mostly a lot of curiosity about the drugs. They have all kinds of questions about what's this drug going to do? After you tell them, they say oh, I don't want to do that.

Rumsey: This type program is being run throughout the country, California, New York City and elsewhere. The evaluation of these programs tend to say they are effective. They have some attitude surveys that measure attitudes,pre and post. This group does work.

Gene: It works better than if you or I go into a classroom. It works better than if a policeman in a uniform does it.

Participant: What do you tell the kids about marijuana?

Student: We don't come to discourage them. We give them the most current facts on marijuana that have been published and we'll try to tell them to the best of our knowledge what it's like. I don't know what's going to happen. We try to tell them.

Participant: Have any of the younger students approached any students on counseling?

Student: I had one girl that came to me. We had a question and answer thing where a kid would write a question down. We had a question box for when we came back the next week. I came in and the kids were still handing in questions. A little girl came up to me at the desk. She handed me this little paper that said, "I like to take drugs, do you?" Most kids you figure, sixth grade, they're going to be screwing around. This kid wasn't smiling or anything. We never really got a chance to talk to her because the next time the teacher told us that she felt it was ineffective.

Student: The teacher kind of told us to get lost.

Participant: I just questioned the qualifications of counselors.

Gene Collacki: Qualified? Yes!

Participant: Sometimes these kids just want someone to talk to. They go to the office or the guidance counselor. They get pushed out the door because there just isn't time. These people might need somebody that could take the place of the guidance counselor.

Student: At Narcotics Guidance Council we have a coffee house where kids can come and counselors are available. They're not labeled counselors. They don't sit at tables. They mingle with the kids. We have these programs at the Jr. High and high school. They are open one night a week to play basketball. There are counselors available there too. In the Jr. High a couple of people I know have done a lot of counseling with the kids. If one's on a bad trip or something like that they stay with them for two or three hours.

Participant: I'm not talking about just kids on drugs. A lot of kids just need someone to talk to. If they don't find that somebody eventually it's going to be drugs.

Student: We're around all the time.

Gene collacki: One of the problems that we have found is the administrat wants a teacher present. This for safety reasons. We're finding that that's breaking down some. Where the teachers have been willing to move out these kids have been able to establish a better rapport.

Student: One of my brothers came home and told my mother, before I was in the program, that 90% of the people that try marijuana are up on heroin. Kids will misunderstand statistics. Maybe 90% of people on heroin have taken marijuana. Thats another real good thing about out project. I straightened out these questions.

Ken Weiner: I'm going to have to break in or we aren't going to eat. If anybody wants to corner these two young men they'll be around a few more minutes.

THURSDAY AFTER DINNER 6/31/73

Mr. Rumsey: I just want to try to bring in some of the drug education program areas. What they're doing and what they should be doing. Thats why I asked Gene Collacki to come and bring a couple of his boys with him, so you get an idea of one program different than others more traditional in nature. By that I mean they don't just show films or do the traditional things. I can quote all kinds of studies to prove that statement.

One of the things we have learned is that teaching alone just doesn't do the job. It doesn't cut the mustard with these kids. Because we're trying to build desirable attitudes we must do it with facts. An example would be the amount of money the government has spent on cigarette anti-smoking advertising. Yet this year cigarette sales increased. Knowledge by itself is nothing. Our programs should be geared to bringing about the skills of decision making. Certain values that we have mentioned must be instilled in these students, somehow. Ideally it would be done by the parents. This often doesn't happen, so I think we have a responsibility to do it. I would say that this group of people, because of their connection with unique children, have empathy and the ability to do a much better job than "the average person" or "the average teacher".

Another factor that I think we should be aware of is that drugs aren't half the problem. We're talking about people. We're talking about life problems. We are not meeting the needs of the kids. You can't usher them into a school and sit them behind a desk for a number ofhours. I think we have to reexamine our system a bit. I'm not saying I'm going to advocate throwing it away. I do think that we need to meet our needs a bit better than we're doing. We just have not been doing it. We do have to become aware of some facts ourselves. Some knowledge so that we can be better informed, I don't think that we need to be drug experts. I think we need to be people experts. If we learn about people, understand them and have a little feeling towards them, I think we'll do the job.

We shouldn't relegate drug education to one period a week in a health class or two periods a week. It's got to be integrated throughout the system and all, everyone, has to be a part of it. In K-12. so it has some sort of carry over. It's not going to be effective on a one day basis.

We can not stop anybody from using drugs or taking the risks that they're going to take. I think that we can try in many ways to educate but it should also be aimed at prevention. Studies found that these kids who are using drugs come from what they refer to as "high risk families", families who use drugs indiscriminately, use alcohol indiscriminately, and don't believe in certain types of discipline for children. They found the kids that do not use drugs come from "low risk" families where there is some discipline. One thing that I think each one of us can do is try to understand the difference between use and abuse. Sometimes we get uptight if we seem someone smoke a marijuana cigarette. A simple use does not necessarily make a person an addict. I think we become reactive. Some of the long range damage Lou has already mentioned concerning tobacco and alcohol. These are drugs that we should be concerned with. We should examine our attitude towards all drugs, alcohol, tobacco, etc. I think we have to examine our attitudes about a lot of things. If we dont, if we have preset or preconceived ideas we are going to transmit these ideas to the kids. To give you an example, I met those 2 boys for the first time today. When I saw their hairdo, well, needless to say it was different. Four years ago I probably would have considered them to be hippies. I realize that this is not as important anymore. At one time I'm sure it was. Hair was important. I have to examine my attitudes and you have to examine yours.

Does every pain need a pill. Isn't there times we can develop some inner strength. Sometimes in a very tough situation just gritting it through is best. These are some attitudes that you're going to convey to your students without knowing it.

I mentioned scare tactics dont work. They're just not going to do the job. We have to give students a clear understanding of the behavior we expect and hold them to it.

We have to give them more responsibility. These kids are not getting responsibilities and I think we have to start providing some for them. It's important that you get teenagers involved in something and they can really do the job. Sometimes we dont listen to kids. We dont ask for their opinion. They have thoughts which are very good. But we treat them like, "yeah thats nice but go away". We dont really listen to them. We have to be honest with the kids. If you dont know something admit that you dont know and find out the answer. Dont try to bluff them. They probably know more than you do. There's no sense kidding ourselves. Its not important to know everything and if you're honest with kids they'll pick it up.

We can substitute what we think we know about drug abuse with what we really know about human behavior we can diminish the problem much faster than we think we can. We've got to focus on the people need rather than strictly the facts.

There is a list of 20 or 22 agencies in the Rochester area where you can refer kids to get help. This is as important as dealing with kids learning. How do you assist them in finding help for a particular problem.

Ken: I dont really know too much about you Doctor, so I cant give you a very lengthy introduction. Why dont you just take over, Dr. McNabb.

Dr. McNabb: Some people have heard me talk before. The reason I'm a little disoriented is that since I now work for the idiots in Albany I was confronted a week ago with information that I had to have a '74-'75 budget in by the middle of June rather than the middle of August. Right now I'm preparing a budget request for some 400 people, and I just finished dictating the draft. I said the hell with it and went home to have something to eat. So I'm very confused and with that I'll start. Tom asked me to talk about utilization of drugs for specific problems and also I have a few slips of paper here on which you have made some comments and questions. So what I thought I would do was make some general remarks and then we could have a bull session.

First of all I'm not going to talk about drugs in the sense of what the kids are doing these days with pot, hash, etc. because I think that the inference of the question bore directly towards the proper use of drugs with kids with problems and thats what I'd rather address myself to. I think its important to talk about the medical aspect and utilization of drugs. With this I'll now launch into some things that may be a major revelation to some of you.

Most of the medical literature which we base decision making on for utilization of drugs, primarily tranquilizers and amphetamines, probably has to be the world's worst literature. Without a doubt it is the worst. As a matter of fact, the first study in which they came to the conclusion that amphetamines were effective with kids with learning disorders, primarily the hyperactive child, was based on only a little over 5,000 cases and there was no standardization throughout the whole thing. It was only a flukey sort of thing. So on that basis the boys who were interested in making money flooded the market with all kinds of pills. We are a pill oriented system. So I want you to understand that there have, in the last few years since the FDA really began to get involved in investigation, the use of some of these drugs, been some fine studies. I happen to, while I was having dinner, thumb through a study which I just came across. Its one which is quoted quite a bit in the use of retalin. When you read the fine print the length of the study was six weeks which is a complete waste of time. It means nothing.

With these remarks I will tell you what I think about the use of these drugs. There are good indications for use of drugs in assisting kids with learning disabilities, hyperactive kids etc. I think that we need to spend some time talking about this. Those who are involved in observing these kids and the physician must have an adequate base line. What you have to do is really define the behavior that you're witnessing. Invariably I see referral alipa that say, "The kid is hyperactive, overactive, short attention span", the usual bit. This tells me nothing. Thats a worthless referral. The reason why is that it does not equate the situation. I do not know the environment that kid is in. If you can take that child out of a classroom and put him 1-on-1 and he sits there and attends beautifully but with 5 kids or 20 kids he starts climbing the wall that's an entirely different picture. So you must equate the environment that the kid is in. This is very, very important. Invariably I get these referrals about the hyperactive kid and the kids not hyperactive.

The next thing I want to talk about is some of the things you as teachers need to do in writing this up. You all have certain behavioral base lines that you use to refer a kid to your mental health personnel in your school. Usually its the kid that bothers you and this is the one that's hyperactive or mouths off, or has a short attention span. But there are other kids in this group also. The kid who's the loner, the kid who sits by himself, who does not become involved, daydreams, may have other kinds of symptoms like motor problems, language problems etc. What you need to do is define your observations, and define your base line.

All of you have techniques of recording your observations. What you better do is look and make sure its constant. Any time that we're going to introduce drugs you have to use some base lines for its effectiveness. This is what the physician should ask if he's got any smarts about him. Not too many physicians do this but they had better start. So you have to define what you're talking about. If you say this kid is hyperactive, at what setting is he hyperactive. What happens with his language? What happens with his motor ability? What happens with his social and intra-personal relationships? etc?

Why do we use some of these drugs? First of all nobody knows quite why the mechanism is out of kilter. There are many theories I'm more and more impesssed with the data coming out of England and Scotland as well as some of the studies in this country. The uterin environment has been faulty? There is more and more data about being able to actually predict the numbers of kids who will be bonified learning disabilities when they hit school. A good study is one from the Simson Hospital in Edinburough, Scotland. I happen to have had the pleasure of spending a great deal of time with Cecil Drowlin and Keith Brown this past summer. Believe me I'm sure their work is very reliable. They have some very interesting statistics. They find that 2.5 children per 1000 live births will have some sort of incidence during the uterine life or within the first few weeks of life in which they will have difficulty. They may have lowering of oxygen for example. Somethin happened in the kid's environment and they can actually identify neurological signs in that period. These kids can be identified at this point and are predicted to have learning and behavior difficulties when they go to school. The history the parents give you is one of normal development. It's a very interesting study. They also find that one per 1,000 live births who sometime during the 6-10 months of life will develop what we call a trancient hemaplecia which is a fat word saying that they develop paralysis on one side of the body. It is a very trancient thing. The reason it is discovered is because of the nurse visitor program which in Scotland really delivers medical care. As a matter of fact every infant age 9-12 months, by law, must have a developmental assessment. This is the whole country. These nurses are in there and they're the ones who identify this. These kids, 1 per 1,000 live births, interestingly enough recover. There is no motor deficiency, but, yet, when he gets to school he has learning and behavioral difficulties. They find another 2.5 per 1,000 live births develop cerebralpalsy from some unknown reason. This occurs and there's no evidence in the birth history of it.

There's also another group of kids to add to this whose mothers have a lousy fertility history. Numerous spontaneous abortions etc. These kids will have difficulties. Another thing is the age of the mother that's important. You'll find that the average mother who is 25 - 35 has got a 1 to 200 chance of having a genetic abnormality but when you hit over forty you drop to 1 to 50 chance of having a genetic abnormality. In some 15% to 20% many of the kids wandering around the Forman Center have genetic abnormalities. Many of them are mild but there's now a classification which has recently been written up by a study of the National Institute of Neurological Diseases which is classifying a large group of these kids. This gives you an idea of the background. I stress this because when you get this kind of information and you have a kid who is not learning then you can pretty well bet your bottom buck that this kid's got a faulty matrix to start with. A lot of the behavior which you see as teachers is really a learned behavior which has been super-imposed on a weak mechanism to start with. This happens to be my basic premise at looking at these kids.

One of the mechanisms, which really is a symbol system to a degree, is the inhibitance mechanism. There is a well-developed inhibitory mechanism in the brain which conteracts impulses. It has been thought one of the reasons wehave different brain waves in a lot of kids with learning disabilities, hyperactive for example, is that the inhibitory mechanism is out of kilter. This is the basic premise why they decided to feed a lot of pills to kids.

The reason I stress this business of history is that if you have a kid who's young with that kind of a history you'll choose one drug versus the kid who seems to have a fairly mild history. A child with not a lot of birth trauma, mom's got a good fertility history, etc. comes to school and gets hyperactive. Then when you analyz the data the teacher says this kid's a perfectionist, got to get everything done just perfectly. If you give the kid a time line the kid starts to get up tight. You're really describing a kid who's hyperactive on the basis of alot of anxiety and if you investigate the family, ask a few questions, you'll find a rather neurotic, compulsive mother who's driving him to do this. The old man is a salesmanager at Xe and the kid has got to be able to read Shakespeare by the time he's 5. He's five and a quarter and he hasn't gotten there yet because he can barely recognize dog, cat and see Johnnie run. So the pressure is appli

Invariably the hardest decision I have is sorting out what, in fact, may be an organic problem versus one which is superimposed by an environment of pressure.

With that now, I will move on to talk a little bit about some of the kinds of drugs, indications, what we're looking for and what I think is an appropriate plan.

There are kids who have bonified learning disabilities which are due to seizures. There was video taping of a couple kids in a speech lab here. They asked me to look at the tape because the kids were having some peculiar behavior and the tape showed some beautiful myoclonic seizures. They were obviously not aware of the fact the kid was having a seizure. This was what was interferring with the kid's ability to develop proper language.

There's a wide variety of kinds of seizures. Obviously the old classic grandmal seizure everybody is aware of. I wont even mention it. Number two is that there are the minor motor seizure which amount to no more than a simple thing like a head droop. Petitmal, mild petitmal attacks will do this. I've seen kids referred on the basis of this alone. I remember one vividly because they moved to this part of the country from Connecticut. The school psychologist and pediatrician told the mother that the kid had these spells and he'd outgrow them. I saw the child. He had 25 petitmal seizures within the first hour I was with him and the family. The child had been doing this for 2 years. That kid was in a trainable class. It took us 3 months to get him under control for his seizures. He ended up in a learning disability class with an I Q of 85 rather than 45 which he was clocked off with originally

Even though physicians will get upset because some teachers say "I think this kid may be having a seizure." When a teacher says that the doggone physician better swallow his good pride and really ask some basic questions of the teacher and investigate. It may put an undue anxiety on the parents but if the teacher and the physician work together appropriately they ought to resolve the anxiety witnin the parents. The primary drugs of course are some of the old barbituates that still are the great old standbys for some of the grandmal seizures. Dilantin is still one of the great choices and there are other variations of this which, for some of the more difficult seizures, types of problems, you may never be able to completely get under control. This is an exceedingly difficult thing for teachers and nurses to accept. You may never be able to control the seizure activities and you may have to accept the fact that this child will go on with these seizures.

Participant: Could you give me just one kind of reference in terms of children who are labeled learning disabled. What percentage would you think would fall in the seizure catagory? Of that percentage of seizures how many would have minor motor disabilities?

Dr. McNabb: A small percentage. I cant give you a figure of what it would be but if you read some of the literature you'll get as much as 15 or 20 percent of the kids or even higher depending on who did the study. Just because you've got an abnormal brain wave doesn't mean that you're having seizure activity. As a matter of fact, if we took a random number of people out of this room right now 15% of the normal people have abnormal brain waves. But nobody considers that as a standard error of the bloody test you know. In medicine if you have a standard error of 15% or less that's a darn good test. My own personal feeling is that you take a place like this (Forman Center) and of the 1,000 kids in the special education group I have been told that there are something like 130 kids who are getting medication. Out of this close to 75 are actually getting anti-convulsives. Out of those I cant answer how many are getting medication because they have an abnormal tracing or because the kid has had bonified seizures. I'd have to trace that down. There is a discrepancy and that is a darn good question.

The next group of drugs are amphetamines which obviously have been taken off the market. It's a very bonified, a very helpful drug but everybody is scared now because of the fact that these are all the various pep pills which flooded the market. But forget the black market. Think about the fact that there are kids with which we have found that the amphetamines work exceedingly well especially with the younger kids, 6,7, maybe 8 or in which there was a positive history of difficulties in uterus or at the time of birth. These children who were hyperactive, short attention span, when given amphetamines did exceedingly well. It did not interfere with their appetite or sleep. They actually simmered down.

I think that this is something that we have to keep in the back of our head that there are these kids who belong to that kind of a population who I feel that amphetamines still, despite the triple forms we have to fill out, is the best drug of choice as far as I'm concerned.

Participant: In regard to amphetamines you were saying that amphetamine use with young children for hypertenseness is properly prescribed, but you aren't suggesting widespread use.

Dr. McNabb: Correct. And that's why I define this age population. I'm going to now go to the use of ritalin which is now the cure-all for all kids according to the drug company. It ain't the cure-all for all kids. But this seems to be more effective in some of the kids who are hyperkinetic and a bit older. The 7-8-9 year old, maybe the 10 year old. I would say that that's probably got to be about the upper limit.

The next group of drugs of course are the tranquilizers. This is a hard one to separate out because the adult population of the United States uses tranquilizers more than they do aspirin according to a recent report. This obviously is another bit of malpractice on the part of the medical group because they pass it out rather than asking the question, "Why do you need it?" It's easier to get neurotic mothers out of the office by giving them one of these prescriptions. There are specific needs for tranquilizers and I use primarily one, and its a very mild one, that's mellaril. We use it primarily in the kids who are very anxious. There are people in Rochester who will use Haladol or Thorozine or all these high-powered things and I think they're sticking their necks out and I hope some of them get sued. They are drugs which have to be used under very, very careful monitoring and these kids are not monitored. There is a tremendously high rate of reaction to drugs like Thorozine. The kids go out in the sun. They get a wild reaction skinwise. This is something that you have to control in a closer setting than you have in any kind of a school situation. I feel that this is really very, very important.

Now, I'm going to quit in about 5 minutes so we can rap for awhile. In recap. You have to evolve a plan for initiating the drugs. The first step in developing a plan is that you've got to have a base line. That's number 1. Number 2 - there has to be an educational cycle evolved before the first pill is given. I'll tell you why. Teachers and parents will expect the pill will be a crutch and cure-all and it isn't. It's only an adjunct in helping with some of the symptoms while you're trying to get to the problem of the kid and teach him something.

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We have found repeatedly that the drug dosage which has been prescribed in all the drug literature is greater than what is needed if a kid has an appropriate pscho-educational program. The kid who gets up to 30, 40, 50, we've seen kids taking 80 milegrams of ritalin a day which is atrocious. When given the proper physco-educational program you will find that within next week you cut the dosage of the drug in half and halve it again before very long. This is something which is not talked about very much in the literature but I think it's exceedingly important that this be described first. When the pill is given you start with a low dosage and you monitor the effect. What one has to do is sit down with a teacher and describe exactly the kind of behavior you're looking for. The teacher who wants the kid to be totally placid and do exactly what they want them to do, well, you might as well forget the drug because you'll never come to that. What you're after is altering certain behaviors. You've got to choose what they are. 1. Do you want to try to reduce hyperactivity? 2. Do you want to try to increase the attention span? It's very important because you have to build in a reporting mechanism at least on a weekly basis. You must know it's not just water and you alter the dose accordingly. Likewise before the first pill is given the teacher and the parents must have a thorough understanding of the sideaffects. With any drug you've got a 15 or 20% chance you're going to get the opposite affect. You know the whole purpose of the amphetamine with the paradoxical effect. The fact that you give them a pep pill and it calms them down, one has to beware. You can give some kid amphetamines and they'll get worse. The same way with any of these drugs. Its imperative that the teachers and parents are totally aware of the kinds of side affects that you can get. Everything from nausea, vomiting and on down the line. You can get kids who are on dilantin for six months and all of a sudden they start walking like the stereotype drunk. The parents get a little upset and the doctor says "God I overlooked a brain tumor". And its all because of the dilantin. I have personally gone through a herendous experience. I remember being called on Christmas Eve by a family who went just out of their tree and rightly so because we had their daughter, who had problems galore, on dilantin. This young lady had been having some alterations in behavior, personality and temperment. Christmas Eve when all the excitement of Christmas really came to a peak this kid lost her control and in exactly 90 seconds dismantled the Christmas tree and gifts in the living room. I went over and helped the family get themselves back together again. I learned that the books taught me such and such about dilantin and I had made a mistake. It's imperative that we really know what these side affects are. One of the interesting things that's happened here is the fact that we see one type of kid the teacher gets frantic about. They really never know how this kid is learning because the kid is a Zombie. Somebody has prescribed drugs on the basis of body weight or square meter of the body surface and never looked at what was going on in the classroom or with the teacher or with the parents. Just blindly prescribed and the kid becomes a Zombie. I've seen them fall off chairs, bump their heads, get lacerations, what have you. Nobody is talking to the teacher or the parents about them. They get mad as hell at the damn doctor. He sits and says "The book says do this and do that". There's no reason for this and I'll criticize these physicians everytime. I think it's exceedingly important that one have this information down and that means before the first pill.

They can't be dispensed as a prescription and after the kid blows his cool, you say, "Well Geez I should have told you that."

The last thing I want to say and this is something which I recently had changed in my thinking, is I no longer will prescribe any of these drugs, other than to a kid who has a bonified convulsion disorder, longer than 90 days without building in a re-assessment. I think this is vital. Some of these kids may not need any more. They can handle a reduction or you may find it isn't doing a darn bit of good. What it's doing is covering up an issue. I've seen this repeatedly with kids who are in a questionable area. They're put on ritalin or something like that and everybody sits back and relaxes. Nobody has dealt with the pressure because the old man is a Xerox Vice-president and he wants this kid to be reading Shakespeare and do calculus at 4. That's where the issue is and why the kid's anxious has nothing to do with the kids processing abilities. The kid's hyperactive because of the kid's old man. These are some of the things that I'm stressing. I feel they are exceedingly important. In quick summary drugs have tremendous aid and support to a physio-educational program. It is no substitute for it. It's only an aid. I think that's the message. I'd like to have people ask questions. I do have some of the questions here that people have asked and I can refer to them if you don't want to be too verbal, but I think that the audience can probably be fairly verbal.

Participant: Dr. McNabb, a number of times you used the term baseline. I'm wondering in the various facets of the environment that a child travels in how do you go about establishing a baseline as such? Is it home, is it school, or the neighborhood. What do we use for an environment?

Dr. McNabb: Let me put it this way. I think most teachers don't learn about kids in their training. #1 premise. That's a good one for openers. The reason I say this is we know a heck of a lot about methodoligy. You know how to record an observation, but you've never been taught what the concept is. Therefore it's exceedingly difficult for teachers. You have to develop a concept first of all. The concept is how does a kid learn and every kid learns differently. Every kid is different genetically. You have to develop some simple models. Therefore, you look at how kids learn. There's a multitude of input and processing of output. If the teacher looks very, very carefully at the observations a teacher can make the diagnosis and develop remediation without all the high pollution experts. They use the experts for advice. Now if you look at how a kid learns, what happens when information goes in. How is it processed and what do you see when it comes out. Some of these things are very, very simple. The kid sees yellow fire engines, the kid gets out of the way. They used to be red when I was in school. Visual to gross motor. What happens when a teacher says this kid is 6 years old and he's still writing his B's and D's backwards and so forth. Is this abnormal or isn't it. What happened when you see that particular kid who invariably does well but mixes this all up. Verbally you say this kid sounds like an 8 year old. He's only 7 but he's reversing. This is abnormal. What happens? Every time I give him something written he gets more hyperactive, he forgets, he can't sit in the chair, or the 9 year old who's very passive. He sits there and he draws. He really can't get going. We have base lines here you see which answer these questions.

Larry O'Neal and Fred Coisman and I have a roaring laugh every week with some of the kids Bernie Greenberger sends up from the city, adolescent retardates. These kids are jumping all over the examining table. Coisman says, "For crying out loud I'm running a blood sugar on this guy." Neal says, "Yes, because they fall asleep while I'm trying to evaluate them pscho educationally." Now there is a very concrete base line you didn't even have to run a blood sugar on them to prove the kid is not hypo glosemic. The kid's a passive agressive, shot down kid in adolescence. This is what I mean of a base line. Not two teachers in this room tonight have the same base line. Everybody reacts intuitively different to a kid. Every one of you has the capacity to react to a given situation on the basis of your experience. I'm challenging you to do this. Think about what's going on. Conceptualize how you teach this information to kids. Work with him. How does the output come out and what do you do to observe and record this information. That's a long story, but I think this is one of the key issues to how you develop a base line.

Participant: Can drugs start seizures to a child who's never had them?

Dr. McNabb: That's a good question. There is one report that I know of, maybe two, of kids who have been put on ritalin who have never had any past history of seizures who have had grandmal seizures. The 2 kids that I know about were about 9 or 10. I don't know anything about the earlier ages. The reason I have a question mark on this is if you look at the incidence of seizure activity in the first 2, 3, 4 years of life you have one big drop after and it begins again at 9, 10, 11. Then 12 and it drops off again. The question I have is whether the cause was there and would have come out regardless of the ritalin or not.

I do not know. I don't know of any data that proves this one way or another. We've argued this among ourselves many times. I can only say that you can risk the side affects of the drug and the physician has to be aware of this.

Participant: I'll arrive in very rare instances where a child should have drugs. I immediately work toward getting them off as soonas I can.

Dr. McNabb: It depends upon what the problems are. Now if a kid was put on ritalin and you should have a brain wave which showed a classic discharge of a grandmal type activity, obviously you'd get him off of the ritalin and put him on dilantin, or phenobarb. So again its identifying and making darn sure you know what's going on.

Participant: Ritalin reacts differently on different children. The one I have in mind was much worse after.

Dr. McNabb: This is why I'm saying you have to have a base line and one must measure it and alter it. It depends upon what the kids problem is. These drugs are pedaled by the drug company as pantecias.

Participant: It's more a mother than it is anything else?

Dr. McNabb: It could be. You have to look at why. These are things that you also have to take into consideration. You could resolve the problem of why mother is upset. Maybe she's overwhelmed by a problem. She needs rest and somebody has to get into that house and deal with that problem. Give her some relief. That may be the best tranquilizer.

Participant: Sometimes the panic button strikes. If she has a retarded child right away everything the child does she has contributed to. Sometimes the child doesn't do anything worse than a normal child.

Dr. McNabb: Now you're raising another problem. That takes another 20 hours which I have very strong feelings about. That is how parents are counselled. The fact may be that they have a handicapped kid, of any kind, whether it's a minimal learning problem, minimal emotional problem, or whether the kid is a bonified severely profoundly retarded kid. Most of the people in the United States, the professional people like physicians, are reluctant to put the cards on the table. Tell the parents what it's like and what happens so the parents wont get misinformation and you really are put up the creek. This is why we have a lot of uptight parents and why I prefer to be bloody honest about it.

Participant: How does a parent relate to a child on dilantin where that child is in a normal classroom setting and the teachers know very little about learning disabilities. You can talk to them about it and they push the whole thing off as being not really much of anything. How can you set a base line for a re-evaluation in 90 days or so.

Dr. McNabb: If you have a kid who has a bonified grandmal seizure you're going to keep him on dilantin for 5 years.

Participant: I'm talking more about petitmal.

Dr. McNabb: Any kid who has a bonified seizure, you've got clinic data, the brain wave to go with and so forth. He'll be on drugs for at least 5 years and will have to be at least a year or two out of seizure activity before you consider reducing the drug. That's a kid with a bad convulsion disorder. What do you do with this kid who's under control in a normal classroom? You do nothing differently than you do with a normal kid. This kid has normal learning processing. You're not going to make statistics of him. This kid is a normal kid. There are two things that you have to do. (1) He doesn't swim alone. (2) He doesn't climb heights. Those are the only two limitations he has. If he has a fit 20 feet up in the air you're going to be dealing with a fractured skull. If he goes the 5 years then goes the couple years without the seizures when he hits 16 he gets a driver license just like anyone else. So what I'm saying is that because he has a convulsive disorder don't label him for the rest of his life. This kid is a normal kid. There's no difference between that kid, because he has a seizure, than the kid with a chronic heart disease.

Participant: Should you inform each teacher this child is taking this medicine?

Dr. McNabb: I think that is important and should be done. I think whenever a child is on medication it's imperative that the school be notified. There are lots of reasons for this. The legality is one but if there was a change in the kids behavior then the right kinds of questions can be answered immediately.

Participant: You mentioned, informing the parents. When they are first informed of the handicap do you feel it's the doctor's responsibility?

Dr. McNabb: It depends on what the problem is. There may be people who have better skills in counselling the parent. For the kid who has a fundamental symbolic associative processing disorder the school psychologist will be counsellor. If the kid has a learning difficulty, has bonified seizures activity or some other medical problems then the physician should counsel the parent. If it's a kid who's preschool age has a language problem it may be your speech therapist who will be your best counselor to parents. Somebody has to get this point across to the parents specifically about where they should go. This is not done either. I'll give you an example of what I mean by counseling of parents.

I was in an open ward in a hospital in Edinborough, Scotland. I say the best medicine I have ever seen in my life is Edinborough, Scotland. I've already told my wife if I've got a bad disease she should get me there, not Rochester. I was completely overwhelmed by the quality of care. I walked into an open ward and a mother was sitting there. The doctor walked up. He said, "Okay Mrs. so and so, we've done this and we've done that. What do you understand about what's been done about Johnnie?" She said, "this and this". He said, "Okay". It went boom, boom. He included diagrams with the whole shabang. It took an hour. Before she walked out of there she knew more about that particular disease than I did. A child who needed brain surgery was examined by a pediatrician, a pedianeurologist and a pediatric neuro -surgeon. A conference was held to determine who was going to do what prior to surgery. In Monroe County they get the brain surgeon and then call someon else afterwards to bail them out.

It's also the only country in the world who has lay people in each county as a lay board evaluating child abuse. I met a lady who ran one of these in Pebles, which is a little town that knits woolen sweaters. This woman knew more about child abuse then I did. She was a mother. I talked to her for two hours because she gave me information I never heard about before. She was quoting Henry Kamp who is from Colorado. It's only recently I had a chance to read his symposium. Henry Kamp she knew about before I did. I read it this summer, just two weeks ago.

Participant: I have a handicapped child. He was born handicapped and he was six months old before I could actually corner the doctor. By that time I felt so sorry for the poor guy. I think he was a heck of a lot worse off than I was. Of 4 specialists no one wanted to tell me anything. Finally a poor intern explained everything to me.

About 2:00 this afternoon I was ready to move to England after meeting a Doctor Schrard. Now after hearing you I'm ready to go to Scotland.

Dr. McNabb: Try Scandanavia that could be better.

Participant: It seems around here any mother who has any knowledge whatsoever about what's going on is a dangerous person. You do not talk to them, you do not associate with them, you run away. You take a different path to the hospital everytime you go. This can get very discouraging to a mother. No wonder sometimes they become neurotic women.

Dr. McNabb: I quite agree, I can't add more you've said it all.

Participant: Let me turn it around, how many times in schools when an issue comes up does a principal deal with the issue? How many times when you have a problem with the old man do you confront him with the problem and deal with the issue?

Participant: When you are going from Dr. to Dr. with a problem you're looking for answers.

Dr. McNabb: That's correct. We have a habit as adults in this country of escaping, not maintaining where the issue is because it gets a bit uncomfortable. We don't want to upset anybody. Because we get uncomfortable do not want to talk about the issue.

Participant: What would you advise a parent to do?

Dr. McNabb: I think the parents have lots of opportunities.

Participant: Any devious thing you can devise.

Dr. McNabb: (1) You confront the physician with the fact that you are unhappy. (2) Ask him what he's going to do about it. You can say you want bonified consultants. If he's smart he will anticipate that before you question him. What you do is get from him at least 3 names of bonified consultants. Then you take your choice and say the same thing to them. The consumer does have the opportunity to say these things. They'll have to listen to them. So what I'm saying the parents have a lot of choices. They may get darn uncomfortable but you can do it.

Participant: What advise would you give us in a situation when you pick up the phone, a mother tells you Johnnie's been started on melarill or Susie's started on ritalin and no one has talked to the teachers. A mother called up a few weeks ago and told me her son was being started on a new experimental drug. Mother happened to be an RN working part time and had excess to a PDR. She looked it up. Mother is histerical. The symptoms on this thing are almost every other paragraph says - end result death. The child had not been given blood tests or anything like that. She's asking me what to do. He developed all the sideaffects within 3 weeks, except for dying.

Dr. McNabb: The first thing you tell her to do is call a lawyer. That would be her first step.

Participant: Good, I'm glad you said that.

Dr.McNabb: As a matter of fact a new law says you cannot use trial drugs in this state without being licensed to do so. That guy is really guilty. Now let me give you an example of what happened with some kids at a state hospital. They sent the kids noon dosages of medicine to Mary Landry and told her to give the kid the pill at noon. Mary had no ideawhether the kid was on the medication, no idea what the drug was, the dosage or anything else. We just told them "You gonna do that, you keep them there." That's caused all sorts of havoc but we got the answers. I don't care whether it's somebody who's working for me or not. If they're not doing that you say, "look".

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Let them get mad about it, because at that point you become the kid's advocate. It's a heck of a lot more important to know what's going on with that child, than to just say okay, we'll do it, because you need to know what the side effects are what are their plans for observation. And this should be said.

Participant: I've heard a drug mentioned. What is tacaryl?

Dr. McNabb: Tacaryl is one of the tranquilizers. It is similar to mellaril. It was used mainly as I recall, in state hospitals for severely disturbed patients, and somebody discovered that it reduced the urinary output. Then some bright guys got on to using it as a drug to give at nighttime for kids who had an habitual form of bed wetting. Interestingly enough you can give almost a barely effective dose and in 65% of the cases, these kids markedly improve. The bed wetting is cured and you're off the drug. What actually has happened is that it's broken the habit cycle. But you don't institute that kind of a drug without a well documented plan. I've seen it given without urinalysis to make sure the kid doesn't have some kind of low grade kidney infection or bladder infection. You have to go through a routine approach. You do not give a kid tacaryl simply because he wets the bed. Many parents seem fearful of the use of drugs with handicapped students. I hope we've covered this. The fact that there are specific occasions it is helpful, that if it's done under the right conditions, there's nothing to fear. There is no indication that the kids who have been on amphetamines have been addicted. There is no literature that shows that kids who have been on long term ritalin have been addicted. So you can assure the parents that if it's done properly, they will not have inappropriate side effects or will they be addicted.

I have some of your written questions. Here's a good one. The question is..."We're responsible to give all types of medication without doctors' approval. Should we?" This is something which is a problem in the city schools. It wasn't too long ago for example that there was a regulation by the city school lawyer that they wouldn't dispense drugs. Every principal thatI know of in the city schools who is really tuned in and cares for kids have a unique capacity in dispensing drugs by putting the pill on the desk corner, turning his back and it's gone when he turns back again. The kid's had his pill. The thing is to protect yourself legally. There must be a written order for the medication, the dosage, the time it's to be given, etc. When that is done by the physician he is assuming the legal responsibility. That will cover the nurse. Now if there is no nurse in the school my suggestion is that the physician write the order, that the parent sign a permission slip for a designated person or persons in the program to give the medication under the direction of the physician. That way, legally, everybody is covered and there can't be any hangup. The most important thing is the kid gets it if he needs it. Only once in 20 years have I ever been confronted by a situation in a school in which we were unable to give a medication. So I think that this can be done with a minimum amount of discomfort to everyone.

Participant: Is there a place that you can go to find side effects, to find out the effects a drug is having.What kind of attention he needs. It's very hard for the teacher to talk to the doctor.

Dr. McNabb: Well it shouldn't be because if you make some nasty calls to him, you'll get him. If you have a nurse in the school there should be a PDR, Physicians' Desk Reference, you can look it up in there. It can give that kind of information. Check a kid who's been on it previously. I would suggest what you do is go back to his anadotal records and read themvery carefully. I've even known, at times, to suggest a consultant role. The principal tries to get the physician to come is and talk about it. I think you can do this. I think when you're in this situation you are the kid's advocate and if you're concerned by all means you ask the questions and go after answers.

Participant: It seems to me that perhaps one positive outcome of a growing concern about drug abuse you addressed before is maybe that we're beginning to look at the lack of a healthy respect for drugs in this country.

Dr. McNabb: That's one of the major problems right there. The whole business of the identity crisis with kids in teens. What happens with their ego development, concepts, their motivations, their ability to socialize? Regardless of the kid's problem in the final analysis there are 2 things that make the kid function as an adult, the ability to socialize and motivation. The primary motivational factor is the kid's self concept.

Ken Weiner: Joe Picciotti is kind of a unique character. He's seen this drug scene from two points of view. It all began when he was a member of the Monroe County Sheriff's department and got into the drug scene through the eyes of a police officer. Since then he progressed into the area of the drug educator. Joe will speak to you regarding the legal aspects of drugs, as he saw it when he was a policeman and as he now sees it as a drug counselor.

Joe Picciotti: The job I'm doing now is quite a paradox to what I did. I've seen public emotion run from fear and anxiety to outrage until where it is now. I feel its probably apathy. Some people want laws to become more stringent while others feel that we should legalize some of the drugs that are illegal now. I'm going to try to give you a very brief law course and hopefully you'll have questions. Basically in the city school district we do have policies regarding drug practices for teachers and counsellors. If we run into a problem where drugs are suspected we follow two patterns. If there's a school nurse we immediately report to her. If not we go to the administrator and report the suspicion of drug taking and then they follow through. As a teacher you may report drug abuse and if it becomes unfounded you're relieved of the civil liability of having to go to court. There is a state law that protects you. For any child under 21 years that you suspect is either a narcotic addict or is involved in the use of dangerous drugs you may talk to a parent regarding it and if it becomes unfounded you don't have to worry about civil liability.

Basically the penal law does not make any provisions for handicapped children. The only provisions for defense is if somebody is arrested for possession or selling of a drug that they are mentally incompetent. This means they cannot understand the charge against them or properly defend themselves. If someone is under the age of 16 they're treated as a juvenile delinquent. Now anyone between the ages of 7 and 16 goes to what we call family court. I think it's important that we understand that possession and selling are the two major crimes involved in the drug section of the penal law of the state of New York. The drugs are broken down into two classifications. A narcotic drug which inclues all the opiates and strangely enough marijuana. We're still archaic in our laws in that we include marijuana in the classification of a narcotic. All other drugs fall under the category of dangerous drugs. Hallucingenics the amphetzmines and so on. There are two types of crimes that can be committed. A felony and a misdemeanor. The misdemeanor of course is the least serious charge. All selling charges come under the classification of felony. What this means simply is that I could have in my possession one single joint stick cigarette of marijuana and I could be arrested for a misdemeanor charge. However, if I offer to give this to a friend, if I sell it for a dollar, or if I even intend to sell it I could be charged with a felony. Felonies start at one year imprisonment, for an adult, up to life imprisonment. Misdemeanors end at the one year time, from 3 months to one year. So basically what we see here is that marijuana as it is today and has been discussed by Lou Frasca and several other people, that it is so easy to get a hold of for young people, and it's probably one of the first drugs, beyond alcohol that most kids try, that just offering a friend, one single marijuana cigarette could put them into the felony classification. All of the misdemeanor and felony charges fall into the basic classification of juvenile delinquency, if the child is less that sixteen. I'm sure this is what most of you people will be working with. After 16 years they're treated as an adult. Therefore they should go to adult court and could possibly face imprisonment for a lengthy period of time. These are basically the two crimes that can be involved with possession or selling of dangerous drugs. Interestingly enough the governor has proposed a legislation, which was eventually passed, about stiffening the drug laws and we have people right now in New York State who are proposing to take marijuana out of the classification of dangerous drugs. It's serious enough so that if you have a student whether they're handicapped or not, they still come under this type of jurisdiction. I do think that it's important that every school does have some kind of policy or guide lines for educators to follow so that they don't get themselves involved in a situation where one of your students tell you that one of the other students has got drugs on him that's not prescribed or not in the original container. This is illegal possession of a drug, if what's in the bottle is not prescribed. They can put anything in medicine containers.

A lot of the drugs kids are getting a hold of are coming from their own peer group. There's a lot of exchange in school, because this is where you see the greatest cross section of students, not to say that they can't act it out in the streets. But basically a lot of students get started on drug abuse in school and a lot of it comes right from the medicine chest at home.

There's not an awful lot that can be said about the law other than you have to be aware that if you take something from this student now you're in possession of it and where do you stand? It becomes a rather ticklish situation.

Now if I do find out that a student has a drug, obviously my concern is that he does not stake the drug or give it to anybody else. I've got it. What do I do? If you don't have guide lines in your school, if you don't have someone that you report this activity to then you have a problem, because you are likely to go to a parent. I was once under a situation that became rather precarious. I eventually had to break confidences and go to a parent. It was the result of information that came back to me about three days after an overdose. Three of the children that had been coming to the drug educatio classes were involved. I had to go talk to the parent and retrieve the drug, because the drugs were coming right from home.

Participant: It's difficult to imagine that someone would have a drug right in their home and not be aware of the fact that it was slowly disappearing. I'm a mother of two teenagers and I cannot believe that

I would have a drug in my home and not be aware of the fact that it's going down.

Joe Picciotti: I know that it's happening and often.

Participant: You're giving me the impression all our drugs are controlled at home. But you also give me the impression people have drugs just laying all over the house.

Picciotti: Well, possibly in your home it's in a safe place.

Participant: It's available to my children but I would know how any drug in the house was being used and for what reason. If it were going down quickly I would ask questions. If I thought one of my children were experimenting I'd do something about it. Don't parents do something about it?

Picciotti: Well.............

Participant: If they do, what steps do they take? Doctor or guidance counselor?

Picciotti:I've probably heard a statement I don't know how many times when I worked undercover that drugs were under lock and key. How can parents not miss drugs. Kids catch on to habits and they know the habits of their parents. If they're taking a prescribed drug whatever it may be, they know at what particular time to remove the drugs so that it's not so obvious to the parent. I really don't know many people that every time they take a prescribed drug count the remaining capsules in the bottle. It would be very utopium if they did. It would certainly cut down one source of drugs. Generally when parents find out about their kids taking drugs it's usually too late. The time to discuss drugs with young people is before it's obvious to you that they're taking them. We're doing it in schools. I think the gentlemen from Henrietta mentioned that they're starting now in the 4th grade. The City School District is doing some work from K-12. The most you can do then is not be flabbergasted, get very impulsive, and say, "How could you possibly have done such a thing?" Then get completely outraged at the child. Obviously the best thing is to keep communicating and not shut them off by saying "How could you do such a dastardly thing."

Participant: You don't always know what drugs the doctor gives you. For an ache or a pain he gives you some long name prescription for this thing or the other.

Picciotti: That's a very good point.

Participant: You feel better and have some left and you leave them in the medicine cabinet. They're there so if you feel you need one a little later on its available. We're all in some way responsible, we're all in some way negligent, we're all in some way obviously in a position where we want to do something about it, or groups like this wouldn't be meeting. Instead of going around and pointing fingers at each other and wondering if the woman sitting next to you has got children taking drugs it's better to think about our own children and howwe can avoid they're getting involved. You brought out a very good point. How many times do we go to a physician, pay the man $25. and we don't even have the nerve to question his mistique or whatever it is that he has written on a piece of paper that probably has to be interpreted with a rosetta stone. You give it to the pharmacist and he goes m m m. He takes it back and he mixes up these various chemicals and he shoves something to you. All you know is how many times a day you're supposed to use. I think it's our responsibility as adults and as parents, to ask what am I taking? Why am I taking it? What will be the effects? How long will I have to take it? We're thinking about dollars too. We know that the prescription we got cost

$8.25. Hell, if we get over with what we've got why not save it in case it crops up again.

Participant: We're hearing more and more about the poor comsumer and we are buying a consumer product when we get a prescription I think to point the finger at the medical profession and say they're giving me this and I don't know what it is is passing the buck. You're paying for that service as you say. I think we ask more questions about the underwear we buy than we do about drugs. Possibly this is a potentially dangerous medicine we're putting down into our bodies. Until people start making demands the medical profession will not answer. We're getting better built cars, better safety features on cars because people have asked them for it. We as individuals, each one of us, must use this approach. We may be able to have some effect. The doctors must respond to us.

Picciotti: I think that's a good point and it's well taken.

Participant: There's no drugstore that can refuse to label any medication that is prescribed for you.

Participant: Labels don't mean anything. The druggist just calls them by 5 or 6 syllable words and they may not mean anything to us.

Participant: I would like to add to the question of what a teacher should do if he confiscates drugs from a student. Could the responsibility lay within the school district as to how it is to be treated.

Picciotti: So far as I know, yes

Participant: I'm a parent. I'm involved in our school district and this is a real touchy subject. How is this being treated? Teachers just don't want to get involved because of the liability. We wonder how this is being treated elsewhere. If the drugs are confiscated by a teacher

I understand there's a problem in getting them analyzed.

Picciotti: Not necessarily.

Participant: This is as far as being a parent confiscating some drugs is concerned. Kids might have brought them into the house. Where does your liability go in this situation. Like a bottle of pills the kid might have on him and you feel the kid is up to no good and shouldn't have them.

Picciotti: We report it first to the school nurse if there are obvious signs of usage.

Participant: There are no real clarifications.

Picciotti: We can get them analyzed through the Public Safety Laboratory.

Participant: But I mean if there's been no clear setup with the school, are you taking a chance of presenting him to the administration and I include the school nurse.

Participant: The law was changed about 2 years ago. It used to be that you had to be extremely careful about this. The law is changed in the city school district. They issue each person a lock. My job is to issue all locks. I have the authority to go into a locker that I suspect, but I never went in without another teacher or administrator there for my own protection. The law was changed 2 years ago to the effect that you may confiscate but you must immediately notify the administrative head of the school. He determines at that point what happens next. He follows a set policy. You are no longer personally involved with the drugs. I think too many teachers are afraid to get involved because of all these strict laws and who want to be faced with a felony rap for possession. I think that we really have a moral obligation if we see a child with a drug or even suspect a child of using drugs. You must remove the drug from them. Give it to the administrator. They have policies to follow.

Participant: You mentioned that a teacher should report it to a nurse or school administrator and they have policies to follow. I wonder what these policies are in Rochester - legal and physco educational.

Picciotti: The administrator of course notifies the parents. There is an involvement. If it's serious enough, if there is symptomatic affect, where the student is acting disoriented and can't operate, check carefully. If you notice a drastic change there has to be some reasonable cause to believe that drugs have been taken. The school administrator will contact a parent and if it looks like a case for a hospital we'll send him to a hospital. Same thing that would normally be done with any kind of sickness. Kids who are involved with drug taking are no different than kids who are involved with mental illnesses whether temporary or long range. If we've got a kid who's completely out of hand and know normally that that child operates and functions very well then we've got to do something about it.

Participant: Let's say marijuana is confiscated what would be done. The kid is functioning okay. Little noticeable change.

Picciotti: The administrator would notify the parents that there was a confiscation of an ounce of marijuana or whatever the case may be. The police cannot question anyone under the age of sixteen. The administrator has the option of notifying police if there is selling involved after the superintendent is notified. There are designated areas to question people under 16. According to the Supreme Court they must have designated areas.

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Participant: Is there a legal obligation on the part of someone, say in the school system, who is aware of a student under 16 taking drugs like marijuana to report this?

Picciotti: In the City School District we are to report any drug taking irrespective of age. Obviously there's not going to be criminal liability on our part. If I know that a student is selling drugs in the school, I have an obligation to report it to the administration.

Participant: I'm thinking of a situation where the kids may be 17 or 18 in high school and he's just at the experimental stage with marijuana. If you immediately contact parents and the principal and work in that direction you may lose the kid. So you're in a conflict, you should do what might be best for the kid.

Participant: I think it's a good idea to bend this rule and we do in the Rochester City School District regarding finding drugs in the school or on a person. If you didn't bend them a little you would lose a lot of kids you might have had the opportunity to work effectively with. From school to school from school district to school district I think you'll find a very strong bending of the rule.

Participant: This was my concern. The legal conflict versus the ethical one. It's a matter of judgment in any case.

Picciotti: I'm just giving you the letter of the law. You didn't ask me what I did, you asked me what the law was and I told you. If you asked me what I did I would give you a different answer.

Participant: I asked the question thinking in terms of a situation possibly I might run into with people in my group.

Picciotti: In working with kids we hear fantastic things. If every time we heard that a kid was doing up one drug or another and we reported it we might as well sit there and stare at the four walls.

They won't talk to us.

Participant: Am I right in understanding that a student over 16 if handicapped has to stand for a felony or misdeamenor if he has drugs with him?

Picciotti: That question has to be determined by the courts. If someone, at age 18, gets picked up by the police for possession of a drug the courts must decide if he is mentally incapacitated The criteria is that he is unable to understand the charges against him and unable to defend himself. I don't know how many people here work with that kind of a person.

Participant: All mine are non responsible. They do not have a high I.Q. Only up to 30 and I would not want to see any of them go to court to be proved that they were mentally handicapped.

Picciotti: They would. In New York State the age of 7 is considered the age of reason and if you're talking about I.Q. versus reason this would hold true. Now the judge doesn't decide this. The judge in court is anonymous term. If this individual is picked up for possession or selling and he did give a friend some of his drugs he would go into regular court on a selling charge. It is a felony. Then the defense can ask for a mental examination. This is usually a 30 day period where he is sent to the County Hospital or Strong Memorial Hospital for a mental workup. The decision lies with the doctors. At the hospital it's either two psychiatrists or a psychiatrist and psychologist who will then report back to the court after the 30 day period. It may be extended another 30 days if the doctors don't feel they've had adequate time to make the proper analysis. But at the end of that period the decision is made by the court according to the findings of the psychiatrist whether or not this individual can actually understand that selling drugs and possession of drugs is against the law. I.Q. is really not the basis for it. It's being able to understand, reasonably understand, the charges placed against you. You don't like it do you?

Participant: No I don't.

Picciotti: I know you don't.

Participant: If they had a chance to do it over again you mean to tell me that they'd be called back in to evaluate his mental problem over again.

Picciotti: Understand now, and I'm sure very few of us here have ever been in criminal court or sat on a grandjury or been involved in an actual criminal case. Let me tell you that the courts are very lenient. The prosecution would take a lot of things into accord. But the crime is still there and it will still be charged as a Class A Felony. That means that you sold a dangerous drug. That carries a life term. If this were to happen to the students you work with they wouldn't know that there was specifically a life term attached to this selling process. But I'll bet you didn't either.

Participant: Yes I did. I feel he's been instructed that this wrong to do but when they are out on the street and they're called children, you know, their I.Q. is probably that of a small child.

Picciotti: Yes, I recognize this. I have two special education groups that I work with at Monroe High School. We have gotten some concepts across to them and I don't use the legal whipping post. I do try to impress upon them that there are these two types of charges and they are serious. There is one other I didn't mention, loitering where drugs are being used or sold. Anybody can be picked up with that. You can go into a friend's house and the police can break down the door and you can be innocently there and be arrested on the loitering charge.

Participant: We're trying to teach them to respect the law and go to the law if you're in trouble the only thing I can see to do when you're out in a small town is list these kids with the law department and if they're out in the street maybe the police would know how to handle a situation.

Picciotti: This might be a good idea. I'm sure that the courts are not so hardened that they don't listen to a defense asking an exception. But you mention they have the I.Q. of 7-9 year olds. The age of reason is considered 7. Oath testimony is age 12. In other words you have to testify under oath at age 12 if so deemed by the courts.

Participant: You said if the child is under 16 the procedure is to call the parent and to go to the administrator if you suspect drugs or if you find drugs on them.

Picciotti: At any age. The reason I mentioned 16 is that 16 is the cut off point between adult court and family court. If we see a student who is obviously impaired by a use of a drug and he may harm himself we've got to do something right away. We must get the student to the nurse or administrator if no nurse is available, then to the hospital.

Participant: When a kid under 16 gets busted you start getting involved with the family court system. Can you tell me what typically would happen.

Picciotti: Generally it would depend upon what he was arrested for. With a serious crime they do an investigation then there's a disposition made. Juvenile delinquency is actually a charge. He would be placed in ahome possibly or he could be put on probation or he could be sent to one of the state schools. There are several options depending upon how serious the crime was, what kind of a background he has and what the court deems worthwhile for the child.

Participant: When they're charged with possession as a felony what would happen to them would they be sent away?

Picciotti: No. Not necessarily.

Participant: When is he considered an adult, the year after he's 16 or when he is 16.

Picciotti: The day he reaches 16 he becomes an adult according to the law.

Participant: What is a youthful offender?

Picciotti: A youthful offender is anybody between the ages of 16 and 19 who has not been involved in a previous felony. A youthful offender is like juvenile delinquency. It's actually the name of a crime. It's supposed to save the 16-19 year old from the stigma of a police record check.

Participant: You said intent to sell is a felony. How do you establish intent.

Picciotti: OKay, it's very simple. I can tell you something that happened. I was working out right in this area and a situation was set up where an individual was going to meet me at a restaurant with X amount of a drug. He was to be there at 8:00 in the evening. I was to meet him at a certain area at a certain time and a certain place with a certain amount of a drug. Now even though there was no exchange of money and even though there was nothing other than him sitting in the car a uniformed sheriff came up and checked him out and found the drug. I had knowledge that he was to be there at a certain time with that amount of drug. That's intent to sell and that's a felony.

Participant: Whether or not here's any exchange of money?

Picciotti: There doesn't have to be an exchange of money. Selling is offering to sell or giving it away. Don't forget most drugs are given away initially. When kids first start the term is turn on. "My good friend will turn me on to some good stuff he's got." Turning on is kid's vernacular is selling, even though he (she) gave it to me, it's still selling and it's still a felony no matter what the amount.

Participant: You're an undercover agent, I'm a pusher. You come up to me and say, "You got any pot for sale? I'd like to buy two ounces." I sell you two ounces is that entrapment.

Picciotti: No it is not entrapment. It's only entrapment if I go to you and you've got a couple of bags of heroin and you don't really like heroin but you want to sell it so you can buy marijuana. But I have a very small amount of markjuana so I give you the marijuana for the heroin. The heroin constitutes a greater crime, so I give it to you and that's entraping you. By giving you a drug I'm committing a crime. Entrapment only involves me leading you into a crime. I'm glad you didn't stump me folks. Thanks.

64A

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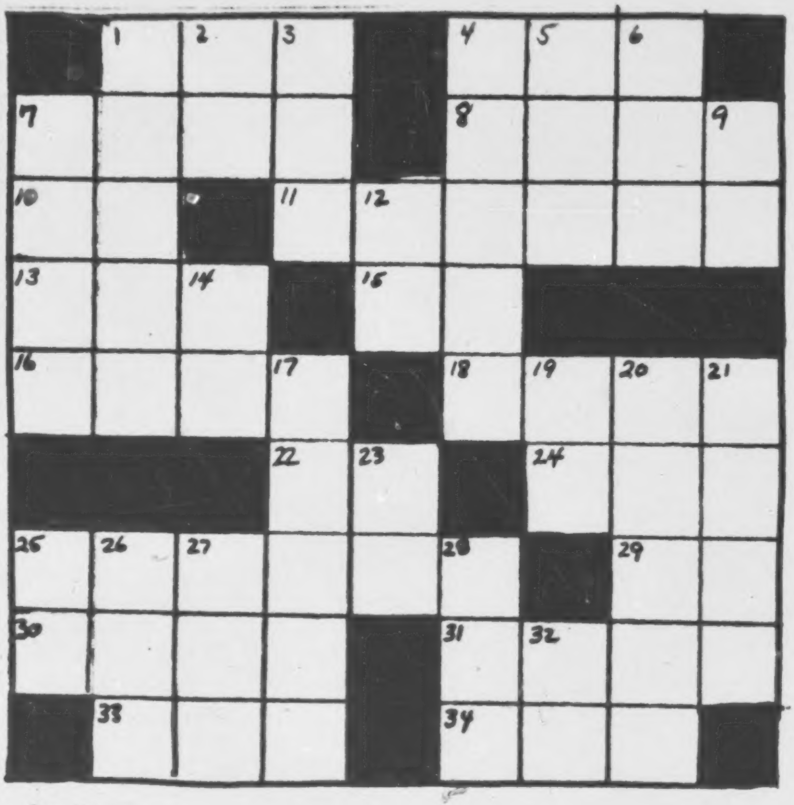
"DRUGS AND THE HANDICAPPED CHILD"

Crossword Puzzle



Across

1. Purchase drugs.
4. Popular term for father.
7. Another name for marijuana is Mary ________.
8. Most common of all metals.
10. Prefix meaning "not" as in "_____known."
11. Cold _________ refers to sudden withdrawal from drug use.
13. Prefix meaning "not" as in "________ Communist."
15. Pint (abbr.)
16. Small barrels.
18. This is what "yes" becomes in popular speech.
22. High School (abbr.).
24. Tennessee Valley Authority (initials)
25. Narcotics also known as "H," horse, caballo and scat.
29. Either
30. Group of three musical performers.
31. Another term for LSD.
33. Likely.
34. Home of a pea.

Down

1. Means of travel on water.
2. One under the influence of 31 Across is said to be ____ a trip.
3. Animal companion.
4. Term used to describe a person who has drugs on him.
5. Noah's boat.
6. Female deer.
7. General term for narcotics.
9. New York (abbr.).
12. To inject drugs is to 17 Down _______.
14. National Guard (abbr.)
17. See 12 Down
19. ______cetera.
20. Keep away from, as from using drugs.
21. Morphine and 25 Across are referred to as _______stuff.
23. Spanish "yes".
25. Height (abbr.)
26. Period of time in history.
27. Tear
28. Short sleep.
32. Combining form meaning "with" as in "_________ operation".

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FRIDAY, JUNE 1, 1973 - EVENING SESSION

Ken Weiner

Last night you got the background, some information on the law and some medical opinions and it was quiet an opinion. Starting tonite we're going to talk more in terms of what is actually being done, what is available to you, where you can seek help and what you can actually do with the people you are dealing with.

To start it off tonite we have Dr. Ying Lin who is the pschologist for the Foreman Center. She will now take over and tell you whats happening here at BOCES I.

Dr. Ying Lin

Yesterday was quite an interesting intensive experience. I don't know how we're going to effect this pill society, this drug culture of ours. I do know that this afternoon I felt I had a little headache. I was about to pop a pill in my mouth. I stopped there and I thought, "Well let's think about it. Let's take alittle walk," and then I got over it. Maybe sometimes a pill is used to readily because they are so available. It's an easy thing. All you have to do is get a glass of water and pop. They're suppose to take care of everything. So I already can see there's some problem, even with me as an individual.

I think the institute planning committee very nicely mapped out a good program for us. This marks the beginning of the educational aspect of drug education. If we got our message from yesterdays speaker, all of them left us with a message saying drug education really has a much

Dr. Ying Lin

broader base than imagined. It has to make sense. Broad based is really education for living or education for coping with how to get along with others. So it's not surprising how the word human development and drug education should be tied together. I kind of like to feel that I will monopolize the human development area. Tomorrow you will get another approach. I'm pretty sure I will relate to this area, but I would like to share with you one approach which I myself feel very excited about since 1971. I was a San Diego based program. A psychotherapist and an education teacher counselor put their heads together. This is very significant and very meaningful for me because the product really is the blending of two disciplines. I myself am quite biased because I will buy anytime what Dr. McNabb said about the psychoeducational planning.

Before you do anything, people in the schools ought to have a plan for the youngsters, particularly the handicapped youngsters because they already have quite a few strikes againast them and they will need that kind of planning for us to help them have a successful educational experience. This San Deigo based program, they call the Human Development Program. As I said, this can be a general term, however, now we are talking about a specific kind of human development program as devised by Besel and Palemaris. Bessel is the one who's a psychotherapist. Palemaris is the teacher counselor educator. For six or seven years the two people have worked together and they have found that in working with either they are patients or they are people who have suffered and are going through despare and agony in the schools. The patients are not aware of what their own feelings, thoughts and actions are. They don't quiet understand the motivation behind there own actions. They also don't understand too much about other peoples reactions. Least of all they didn't understand about people interplay, interaction and reaction from others. They seem to all suffer this kind of agony.

When we talk about drug abusers and really get to know them deep down we find that they feel very unsafe. They feel that they have failed many people including themselves. They've failed everything they have touched. They probably also don't know what this interpersonal relationship is all about. So in a sense this whole spectrum of people with pathology or maladjustment including the drug abusers. They all seem to suffer the same kind of agony. The San Diego Research said, "If that's the case why don't we start from the school where you have the children when they are young and start to teach them how to overcome these kinds of feelings. If we teach them young enough and start as young as pre-school, 4 years old, and all the way up the education ladder then would they beable to become an individual who's more sure of himself. A person who can cope with all kinds of stresses and crisis in life. One who knows how to cope with the problems of life and who also knows what it means to interact with other people. He can perceive other peoples actions, also in turn can act accordingly."

Isn't that what all we all want? So they started out in 1968. They went to nursery school children to start a large scale research. They wanted to see what kind of topic will make the children tick. What kind of topic the children were interested in. Would they talk at all? How about the parents? Would they like it? Would the teacher do it? From the developing evolving process they found that the teacher would do it, but you have to provide them with a concentrated frame work. Will the parents like it? If you share the information with them they would. If they know what it's all about. The children, would they talk? Oh boy, they found that out for sure. They found they could sustain their attention far more than they thought they could. Surprisingly, when they talked to the children, the children became hyperactive. When the children were involved in the talking and they become the listeners, to their surprise the children could sustain their attention much longer than anyone thought possible. So this is quite a revolution because no matter which journal you go to and get a study, one very outstanding feature is teachers always tend to talk alittle bit to much. We can not get away from the traditional way of imparting knowledge by lecturing. If we don't talk a lot we feel we haven't talked at all. Sometimes we have to take the time out to talk with the kid about something really important to him. People ask, am I safe, am I going to fail, am I going to be accepted? We also constantly feel what is called the "delution of uniqueness." We feel we are different from other people. Different, therefore, we must be inferior. The human striving is what makes the agony.

We all aspire wanting to achieve competence. We all want to seek approval. What can we do? The process is really simple. A teacher in the class must gather the children and form a circle. Do not use a table and chairs. Just a circle with the children directly facing each other. If you are dealing with young children they sit on the floor. If you're dealing with older children you may have chairs to form a circle. Sometimes children call it a magic circle. Indeed there is magic when the circle is formed. We have seem this time and again. Without the table and chairs as a barrier you do feel that you can let your hair down a little bit. There is nothing between you and the next person except the air. With a circle it symbolizes a lack of statues or social order of some kind. Also, it is much easier for you to make eye contact so it is much easier to look at people and catch their attention. You try that and indeed the magic will happen. The children love it. Teacher and children sit down in a circle and talk usually between 20 and 30 minutes (no more than 30). The teacher would use a lesson guide to introduce a topic to the children. The teacher would be the one to start it out by going first, or giving an example. He or she would relate some kind of personal experience to the particular topic. Let me give you one example to show you what the topics are. In the fourth grade manual, there is a weekly message. Each day you have a topic relating to that message. The general topic for one week is How I Got Into Trouble. On Monday the topic is "I Didn't Know I'd Get Into Trouble". Tuesday, "I Knew I Would Get Into Trouble If I Did It". The third day, "There Was No Way to Audid Trouble." The fourth day, Somebody Got Me Into Trouble." The Fifth day, "The Worst Trouble I've Been In." This is just one example of getting into trouble from every aspect. Helping the children to relate their personal experiences to the topic. Immediately, you might say how is this different from all the sensitivty training or the encountering work that we have heard so much about? I really felt working with the maturing youngsters would be quite different. Their ego is not quite mature. Their still learning, still maturing. Their sorting out process is somewhat limited. They do need a slightly more protective environment approach. I feel this particular program seems to work.

The children have to observe three basic rules. #1 sit reasonably still. #2 one talks at a time. #3 you must listen. If you are dealing with very young children, the children love to play the listening game. They feel that this is one eay to show that they really did listen to each other.

When we first introduced the program and were dealing with the younger ones. We talked about what we had for breakfast as a way to warm up and

Dr. Ying Lin

get them to be envolved. Children of course love to talk about what they ate, because this gives them certain gratifications. It is something not very threatening. Everybody eats breakfast. It's nothing that you reveal so it's a nice way of starting. We have found this to be very successful thing with us. You get a very accepting and warm atmosphere. You address the children by name. By calling them by name, treating them courteously, talking ver seriously of things very important to them, make them willing to accept you and open up.

Because this particular program is designed for normal children, when we brought it here in 1971 we knew we must do something to adapt the program and then make it possible to be a successful experience for our children.

In order for the children to feel they will gain some awareness, gain some masterful feeling and confidence in themselves and learn something about interaction you yourselves have to also be there with the children. In other words this is almost like a program you and the children in your class can both grow together with. We designed the program so that the psychologist and the teacher act as a team. Here I'd like to say that teachers teaming up with psychologist does not mean that teachers are here to learn only, psychologists must learn too. We mean for the two people to be a sounding board for each other, to take turns being observers and leaders. You will need that in order to catch all thats going on in the meeting.

Right now at the Foreman Center if a teacher wanted to cancel out a circle it is a big thing to the children. We meet once a week. All the people participate in the circle. The first year we had ten to twelve classes and all the teams plus their teacher aides came for inservice.

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Dr. Ying Lin

So with this frame work the teacher gathered the children daily for 20 or 30 minutes talking about things which revolve around three areas, awareness, mastery and social interaction. With that happening everyday you can imagine a youngster starting from age four working with this. We also have about 200 retarded children and we do feel that we also want to use this approach to work with them. Later on you will see in our video tape that we have some retarded children we have begun to work with. They seem to be enjoying the circle just the same as the others. On the tape in the first group we have the psychologist and teacher teaming together. The second group is a retarded group with psychologist and teacher teaming together. The third one has the teacher doing it by herself. She had a year of experience doing it with another psychologist. She felt that she would rather do it herself. Then the fourth teacher is by herself. So you have an assortment.

Participant

This is so much basically like the program that we're running in our schools now. I wan wondering what your experience has been with numbers. I feel personally anything over 10 or 12 seems to restrict the open discussion.

Dr. Ying Lin

Yes that seems to be so with us. We have tried with a group of 16 kids. It seemed there was not enough time to go around. It's very important that the children have a chance to talk. You also have a chance to reply saying, "That was an interesting opinion," even if you disagree. We do find that 10 is a good number.

(VIDEO TAPE PLAYED)

You saw 3 adults. One was a psychologist, one a teacher and one a

Dr. Ying Lin

teacher's aide. There is an advantage in having different levels of people or people with different backgrounds. The children get into the stage where they raise their hands in a very orderly fashion. They are able to talk about their mixed up feelings. I think that is progress. Did you notice the girl in the retarded group with long hair? She is hearing handicapped so the teacher had her close so she could read the teacher's lips. Even with the two handicaps she fuctioned well in the group.

Participant

A point of interest on this particular tape. Just before, the child who was leading the session, was quite upset and was crying. She was quite hysterical. In a few minutes she pulled herself together enough to do this tape. We debated whether we should do it or not, she demanded that we do.

Dr. Ying Lin

Did something happen to her hearing aid?

Participant

I think that was what it was.

Dr. Ying Lin

Marianne was the leader. She began the topic by saying, "Today we are going to talk about wishes." Even the teacher had to raise her hand to get a turn. I think things like that seem to have some kind of impact on children in how they perceive adults and in how they relate to each other.

Participant

I wonder why they were trying to guess what made the girl unhappy. Do

Participant

you think probably because they would, more or less, express why they are unhappy by trying to guess why she was unhappy.

Dr. Ying Lin

Yes, I think that was an interesting question because they deliberately tried to kind out by saying let's talk about what makes us feel angry which is a more direct and somewhat more threatening kind of topic. If you ask "What makes Betty angry?" then everybody can quess why she is angry. Usually they say what they think will make themselves angry. The person will have the final say. She has to say no until they guess the right thing and then say yes. So they take turns making it more like a game situation.

Participant

That was an educable group?

Dr. Ying Lin

Yes.

Participant

Just to add on. Some topics like the wish where the group guesses what one child wants. The group begins to observe what they really might want or what makes them frightened. Sometimes it's an interesting thing for the child who is the one being guessed at to realize other children in the class know him pretty well. Sometimes there's real reactions on that childs part.

Participant

Don't some of these kids realize whats bothering them? Sometimes a kid doesn't know what he's frightened of. Some of the people around him realize he's afraid of something or a frightening experience and they might relate it to him before they even realize it.

Dr. Ying Lin

This is very possible. When they introduce the topic of what makes you angry, something comes to your mind when you raise your hand. But look also at that boy Larry who is a very very shy child. You go in a class and normally he doesn't say a thing. Here you can just watch his expression. At least he's trying. He's part of the room, he's part of the circle, he's very much with it.

Participant

What does a teacher do in the event that the child does not participate?

Dr. Ying Lin

Usually we can go in several ways. At times we get them to just say pass. But what you have to realize is that some children are ready and only need an invitation. You can judge that if you know your children. If he's about to move, give him a little push.

Participant

If you say a teacher or psychologist knows a certain child has some fear or anxiety that it might be best to be brought out. So you try to so this somehow yourself?

Dr. Ying Lin

No. The beauty with this program is it's so dynamic, you have it so planned , that the person wanting to take a slow pace can do it. So very little probing goes on. Actually, it's not typical to keep on asking why. Sometimes you do feel tempted to do that but as a rule we don't probe.

Participant

How might probing help a child in learning to cope? Is the program for the child who can not follow the rules of the group?

Dr. Ying Lin

In case he can not absolutely can not, interact with others, if this is

Dr. Ying Lin

what you are talking about, maybe he shouldn't be in the group yet. But most of the children, we have found, can interact. Occasionally we have found a distructive child that we may have to touch physically. We must control this way because he is acting up. He's throwing paper balls at the ceiling or something like that. You have to control him. You may have to remove the child from the circle which is an entirely exceptable practice. We do make sure that he's not being rejected. We say, "Obviously today you just have to much on your mind." or something of that nature and then someone will take him to a different room to join a different group. When he is ready he can join us again. This problem sometimes occurs but there are ways of handling it.

Ken Weiner

If we do have a problem, if we do find some of our students, some of the people we are working with into drugs or on the verge of being into drugs where can we go? Where can we send them? Can we make some suggestions of places they can go other than to us for help? One of the places is called The Center on Alexander Street. We have the director of The Center with us tonite. Mr. Peter Essley will tell us something about his organization and what it does.

Mr. Essley

I'm happy to be here this afternoon. What I'm going to do is give you alittle introduction to what The Center is all about, some of my feelings about youth services and drug problems, and what can be done for the adolescent in need of help with a drug problem, particularly handicapped youth. Then I'll deal with questions. I'd really be most interested in answering your questions and that will probably be most helpful to you. Let me fist give you an introduction to who I am and what The Center is and some of my thoughts. I am the director of the Center which is

Mr. Essley

basically a resource for high school youth in all of Monroe County. We provide a variety of services for any high school age person looking for information, wanting to talk about a problem, seeking help in a crisis, wanting to help in the community, looking for volunteer work, interested in changing their schools, and whatever. We're open Monday thru Saturday from 10:00 in the morning until 11:00 at night. We try to be there during the hours somebody might need us. We're located at 293 Alexander Street, which is right near the heart of downtown Rochester. Our phone number is 454-3083. We basically view ourselves as a resource for any kind of high school problem. We provide a variety of services for high school students. Our services are one of our basic philosophies is to provide our services by young people for young people. So we have a director who's pretty young and all of our staff is quite young. We have six full time paid people on our staff including two with maters training in counseling. There's a very extensive volunteer staff, well over 100, including high school students, professional and para professional volunteers. Professional volunteer counselors, volunteer attornies, volunteer social workers, consulting psychiatrists, and some medical people. Probably the one component of our program that you people would probably be most interested in is our counseling services. We offer a complete range of counseling services for any kind an adolescent might need. That would include a family problem, a drug problem, a sex problem or health related problem, peer relationship, or school problems. We also have some specialized types of counseling such as vocational and college guidance counseling. The legal counseling is handled by a team of 7 volunteer attornies and we answer any legal question relating to the rights of people under 21 years of age. That might be a student's rights question or it might be a legal question relating to family concerns, parental rights, drug laws, or any other kind of legal questions. Our general problem

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Mr. Essley

counseling is probably the most important and that includes the drug counseling area. We try to relate to kids on a peer level. We're trying to, and I think very effectively, do something which most counseling services really can't attempt to do and that is to provide professional counseling service but provide it by young people. We have a very young counseling staff, age 21-22, but a professional counseling staff. Two of the people on our staff have masters degrees in counseling. We have serveral volunteer counselors who may have graduated from social work or counseling programs at one of the area colleges or might perhaps be enrolled in the social work program at RIT or Brockport or the counseling program at the U of R or Brockport and working for us a certain number of hours a week as a volunteer and still fulfilling requirements at school. So we have a counseling program which relates to kids as peers but with real professional skills. We are able to attract kids with a wide variety of problems. All our services, of course, are entirely confidential, free, and voluntary. We can't help a kid unless he's interested in seeking our help, but if the kid is interested in talking to someone about a problem we certainly can deal with it effectively. We've been open about 15 months now. We opened March 1, 1972. We've been growing very rapidly ever since. It looks like we'll be around for a while. Our counseling program has been very successful in dealing with a complete range of problems, including in the drug field all types of drug abuse from heroin addiction to amphetamines, barbituates, cocaine, hallucigenics, marijuana, alcohol, and whatever you can think of we've dealt with it. Another very important factor is dealing with all types of kids. We're not going to serve just the Alexander Street area. We're not trying to serve just the town of Parma or the Fourth Ward of the City. We're trying to serve the entire county. Because of that we deal with a complete range of kids of high school age. About 40% of the kids we're

Mr. Essley

dealing with are city kids, about 45% are from the various towns throughout Monroe County and about 5% are kids from outside Monroe County. We're dealing with a 15% minority population which is pretty much the same as the minority population in Monroe County. We also deal with a complete cross section of economic levels.

I can talk in further depth about the type of drug issues we deal with and how we deal with them, but I'd like to just fill you in on the general overview of services the Center provides. Besides the counseling program we operate a telephone information referral and crisis service. We're getting over 500 calls a month from young people and also adults who are working with youth or parents who are concerned about a young person. We are dealing with all types of problems, suicide, drug overdoses, runaway youth, family crisis and also a wide variety of information calls. Kids calling up wanting to know what there is to do on a Friday night or to get involved in volunteer wotk. Agencies are calling up wondering if there's a specific agency that will be able to deal with a specific type or problem. Or they are looking for some special type of information. We have become very adept at dealing with all types of referral and information types of calls. We also operate a big brother, big sister tutoring program which is designed to match a younger person (15 or younger) who might be in need of a big brother or sister to an older person (18 or older). We're able to set up a companionship relationship which is very similar to a big brother, big sister relationship with one young person relating to another young person. We have our own training program and selection process. We currently have about 30 active matchers of big brothers and little brothers. We operate a volunteer job service which this past month placed 99 young people in volunteer work throughout Monroe County. We operate an education office which was originally funded through the State Education Department and is now funded through the assistance of the State Division for Youth. We are helping

Mr. Essley

schools set up programs that involve young people in the community. It's part of the learning process. We're working with McQuaid Jesuit High School program which lets seniors out of class for two weeks during the winter to give them the opportunity to work in community agencies. We're working with Nazareth High School in a program of mini-courses where students and groups persue a 10 week course in a particular interest. We provide resources and guidance for students to persue topics on independant study. We're doing this with several different schools and programs to involve kids in the community as part of the learning experience. That seems to be working very well.

I think it's meeting some trends of the future and I think you'll hear more about it as time goes on. We also have a library with over 3,000 volumes designed to attract the interest of high school people with good selections in the areas of drugs, sex and health related concerns, legal rights, and selective service. These are concerns a high school person faces upon graduation. We provide information on employment, colleges, vocational oppotunities, career opportunities. Then we have other sections of just general interest for high school people. We offer meeting space to high school groups. Currently we provide meeting space to 75-80 youth meetings over the course of the average month. Many of those are meetings of the Teen League of Rochester, Hike for Hope, and Bike Day. Also groups from different kinds of projects in their schools meet. Basically what it adds up to is were a Center for high school people, for anybody who has a problem or needs help, wants to get involved in the community, is working with other students on a project, or needs a place to meet. When I was asked to come and speak tonite, Lou suggested that I might talk on more than just the Center, but also youth services throughout the County that might be relative to the needs of handicapped youth and particularly relative to the needs of the handicapped youth who might

Mr. Essley

have a drug problem. As I've said before on other occasions, and I think it's workth saying again, there are literally hundreds of services in Monroe County, not to mention the surrounding counties, that in someway or other provide important services to young people. If we were to just talk about the services in Monroe County that provide help to young people with drug problems we could talk for hours and I could list 50 or 60 agencies off the tip of my head.

Your concern primarily is education, education for the handicapped. You don't have time to deal with questions of "Well what it somebody has a drug problem, where can I go for it?" That's our job as a county wide resource for both young people and those people who are working with young people. I guess the important point that I want to bring across is that we have information at the Center on literally hundreds of people with different kinds of problems. Many services for youth are localized to a particular geographical area, the 19th ward youth project, the Central Teen Center, the Brighton Youth Agency, many of them deal with a particular type of young people, The Puerto Rico Center, or the Black Teens Organization. Others only provide specific kinds of services such as services in the sex area or maybe just a telephone hotline service. It would be impossible for me to try to discuss what all of these services are but it would be much more reasonable for me to point out that if you do have any kind of problem with a young pweson and your not sure what resources are available in the community there is a place for you to call, that's the Center. The Center is there for young people and it's also there for you for any kind of problem. You have our address and phone number. I'd really like to answer questions particularly related to drug issues.

Participant

Are your services available to other towns?

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Mr. Essley

I made the pitch last week to Monroe County Youth Board telling them that we'd like lots of money next year and luckily enough they approved our project. I got the feedback afterwards that they were annoyed that we provided services to 5% of our people from outside of Monroe County and that maybe we should be getting some money from the other counties. We provide services to anybody who seeks it and welcome calls for help from the other counties.

Participant

Is this a walk in service?

Mr. Essley

We're a very informal operation. Our people come to us either by walking in or by calling. We always have a counselor available and usually two. We can handle any prblem at any time. If we're seeing somebody on a regular basis with a special problem we generally appoint a regular time.

Participant

Do other cities have centers similar or is this unique to Rochester?

Mr. Essley

All urban areas have different kinds of youth services. One of the things we found when I attended the annual conference of the New York State Association of Youth Bureaus and Youth Boards was the counties represented felt that they really didn't have a service like the Center.

Participant

How does your big sister, big brother program work?

Mr. Essley

Up until now our big brother, big sister program has operated in Monroe

Mr. Essley

County and generally the little brothers and little sisters have been City residents just by the nature of the program and there particular needs. I would be very happy to explore filling the needs of another communities and I think one of the things we've done on a number of ocassions is provide our expertise as consultants to other communities to help set up a program.

Participant

Who are these volunteers? High School age or older?

Mr. Essley

In our program there almost entirely college are or just slightly older. We recruit from the college program and make a real special effort to get kids who are interested in human services and maybe have some training. Any of the big brothers and big sisters are in training social work programs and human services in Monroe Community College, or something like that. They have more than just an interest but real knowledge of what it's all about to be involved in a helping relationship and then we carefully select them and put them through our own training program. There's a 35 page training manual for each person and a certain number of hours of orientation and training that are required and then regular supervision consultation as the relationship continues. Most of the younger kids that are envolved in the big brother program have a history of fairly significant emtional problems. Of course there are many kids who really don't have severe problems but could really benefit by the big brother relationship and we'll do our best to meet their needs as well.

Participant

How do you find out who would be eligle to be a companion for the youngster?

Mr. Essley:

We get referrals from a variety of sources. Most noteably, school teachers or counselors, the family counseling agencies in the city, family court, probation, and our own counseling program.

Participant

What age group does that cover?

Mr. Essley:

We deal with young people 15 and younger.

Participant:

Do the majority of the youths that come to you with a drug problem come on their own or as a result of someone seeking help for them? What are some of the approaches you use in helping them?

Mr. Essley:

The vast majority of kids we see have some help. In many cases they have help of a guidance counselor or a teacher, a big brother of their own, or a friend. In many cases they come directly to us. They have sought help and sometimes someone like yourselves have made the referral to the center. We find it very difficult dealing with the parents who might call up and say, "My Johnnie has a drug problem, I want to straighten him out." We can help those parents but we really can't help the kid. We try to help the parent understand that unless the young person wants help there is nothing we can do. How do we deal with the kids who do come in? First of all we do our best with the whole atmosphere. The center is designed to make the young person comfortable. It's not an office atmosphere with a lot of desks and typewriters and sterile walls and floors, but it's a comfy kind of peace. So our first thing is to make the person comfortable then develop a rapore with him on a professional, but also a peer level basis. From there we will deal with what ever the young person is interested in dealing with. We explore his concerns and problems. We try to develop an understanding of him. A counselor will develop a plan to deal with the problem. For example if its a sex related problem or a contraception or discussion on abortion we might make a referral. If its really evident that parental envolvement be a requirement for dealing with the problem it's likly we'd be making a referral to one of the family counseling agencies. In instances that our own counseling is sufficient we will keep dealing with the young person on a regular basis.

Participant:

Have you had many requests to provide services to the handicapped? Could you list some of the problems?

Mr. Essley:

First of all it would be interesting trying to define handicapped. Most of the kids we're providing counseling for are in one way or another handicapped. In terms of the traditional definition of the physically or mentally handicapped we do provide service to that type of person and do get requests for service. It would be a complete range of adolescence types of services. We have gotten requests for services with a young person with a physical handicap, who is lonely and needs some companionship. That's something we can provide. We're really interested in meeting the needs of a couple of people at once. So you might be able to match a lonely elderly person with a younger person who may have some kind of physical handicap and be able to meet the needs of two people at once. For a person who's physically handicapped and wants to do something useful we can provide them with volunteer work with another organization that needs help desperately. Things like addressing envelopes, stamping envelopes, to more complex research and thereby meet the needs of another agency and also help the handicapped person at the same time. We like to do that kind of thing. We have gotten occasional requests for service for the blind or deaf although it's not something that comes to us frequently. One thing we can do is develop an approach to meet specific problems. We do have and can provide counselors who can speak the language of the deaf. I think the handicapped do have the same types of problem that young people do and that would go as well for the drug abuse area. Handicapped youth are as likely, or perhaps even more likely, to be involved with drug abuse problems. If their handicap is something they're concerned about and they're trying to really establish themselves as an important member of a peer group then they're likely to suffer even more from peer pressure which is of course a major cause of drug abuse.

Participant:

Have you received phone calls from families who are seeking help for the mentally retarded child?

Mr. Essley:

We have received a few calls of that nature. When we have received that kind of call we do our best to help the parent find the appropriate agency.

Participant:

I was wondering how you make the high school youths in Monroe County and outside of Monroe County, aware of the center?

Mr. Essley:

We have a very comprehensive approach to make young people aware of what we're doing. We advertise on the radio, the youth radio stations. We have a very carefully organized system of school representatives. We have one or more high school student from each of the 40 high schools in Monroe County working with us as school representatives helping us reach the school population. We have posters in the schools, announcements in the schools, cards we pass out and we do our best to be places where young people gather. It's r really a complete thorough approach to reach young people wherever they are.

THE CENTER

293 ALEXANDER STREET, ROCHESTER, N.Y. 14607 454-3083

designed by youth to provide services to Monroe County high school age youth

THE CENTER OFFERS THESE SERVICES:

COUNSELING:

—Informal counseling for young people looking for someone to talk to about drug problems, family problems, runaways, loneliness, and other questions. Counselors are available Monday through Friday from 10 AM to 11 PM and Saturday from 1 PM to 11 PM by appointment or walk in basis.

—Legal counseling for legal and student's rights questions for young people under 21 (arranged with volunteer lawyer). Also, draft counseling.

—Group counseling experiences designed to explore communication, personal concerns and such special topics as drugs and family problems. Groups of 6 to 10 meet weekly under the supervision of a trained group leader.

—Guidance counseling for post high school planning, college and career opportunities and educational alternatives.

TELEPHONE CRISIS, REFERAL AND INFORMATION:

—Call 454-3083 for any youth related questions or problems. Counselors answer phones from 10 AM to 11 PM, Monday through Friday and Saturday from 1 PM to 11 PM.

YOUTH RESOURCE LIBRARY:

—Complete resources on topics of concern to high school youth including drugs, college, careers, legal rights, the draft, sex related concerns, volunteer opportunities, Black literature, religion, psychology, women's literature etc.

VOLUNTEER JOB SERVICE:

—Places high school volunteers and groups in a complete variety of volunteer jobs and service projects.

EDUCATION OFFICE. (Located at 267 Alexander Street, Phone 262-5161)

—A community resource center for Monroe County public, private and parochial high schools. Helps schools and students establish community-internship programs, mini-courses, career "shadow" programs, and independent study options. Arranges for community speakers to give presentations in classes and assemblies.

RUNAWAY ADVOCACY PROJECT:

—Provides services for young people who have left home or are considering leaving home, including emergency temporary housing and crisis counseling.

MORE:

—Provide meeting space for youth groups.

—PASSAGE, a big-brother big-sister program.

—Consultation and information for other agencies, schools and individuals.

THE CENTER is located near downtown Rochester at 293 Alexander Street. Funding for THE CENTER comes from the New York State Division for Youth, New York State Drug Abuse Control Commission, Federal Division of Criminal Justice and private donations.

• ALL SERVICES ARE FREE, INFORMAL AND CONFIDENTIAL •

THE CENTER, 293 ALEXANDER STREET, ROCHESTER, N.Y. 14607 (716) 454-3083

We do our best to keep in touch with school newspapers and spread the word through them. Chances are really good if you ask a young person they've heard of the center. If you ask a parent chances are they probably haven't. That's just the function of our publicity and as we become known maybe that will change clowly.

Participant:

Having had such exposure to problems of youth you must have done some thinking about why and what's the root of some of these problems in our youth's society. I wish you'd share some of these.

Mr. Essley:

I have a lot of thoughts on why the young people are where they are in the year 1973. It's not easy for me to pinpoint a particular source of the problem. I can't say that the problem is that parents don't know how to bring up their kids, or that the school system is insensitive to the kids, orthat society as a whole teaches a young person to dislike himself. I really can't identify a particular factor. I think it's a series or combination of those factors which make up those environments. Some individuals inherited characteristics which will lead to a young person's problems. I think when we talk about drug abuse specificly there are some general concerns which surface regularly. Young people often are concerned about society. I think there is a certain amount of effect that our time in history has on people. There is a certain amount of effect that TV, atomic weapons, pollution, and so on have on young people and their attitudes toward the rest of their lives. I can remember when I was in high school it seemed likely that the United States and the world in general was headed on a very bad course. Problems with over-population, environmental dangers, atomic weapons and so on have an effect on young people.

Participant:

Do you think its going to get better? Is it possible to get better?

Mr. Essley:

I'm an optimistic person. A lot of my response boils down to how I personally feel about life and I'm enjoying it. I can't give a very professional guess at what the futures going to bring. I think young people are showing a renewed trend towards involvement with other people and continuing the trend away from political confrontation and involvement. I think that's going to continue for at least the next two or three years. Beyond that it remains to be seen. what is going to have a significant effect. We can't predict with validity.

Tom Rumsey:

"Brian at 17" is not a typical drug film. It is not going to give you any pat answers. What it is is a story about a boy who's 17 years old. It shows you his environment in school as well as outside the school. Brian is not and actor, his mother is not an actor. The individuals in the film are true people. This is on their location. All I want you to focus on while your're watching this is "What can I do?" Think of the things you could do in this situation if Brian was your student.

FILM: BRIAN AT 17 SHOWN

Rumsey: We'll break up as we discussed in the beginning.

The Institute broke up into two groups and the film was discussed.

The next speaker will be Jane Porter from the City School District Drug Program telling us what is happening in the Drug Education Department.

Joyce Porter: Lets just begin by telling you a little bit about myself which will color my thinking a little bit. I'm a registered nurse and I worked in nursing. Even with my children and everything else I decided to go back to school and study health education. So I came out last January with a degree in health education and I joined the City School District, so I haven't been a teacher very long. When we started out last year we weren't sure what we were going to do, to be perfectly honest. There were three people in September and by January they realized we were having problems, so they drew everyone together and decided we'd do it on a demonstration basis so that we could kind of feel what was needed and where we were at. There were very few materials that were available and so it was kind of left up to us to develop our own and that's essentially what we've done through the help of some of the curriculums, the standard curriculum and the National Clearing House. I don't have all of them along. There are some others that have colored our thinking very definitely, also the drugs, the alcohol and the smoking books. There are things you can get from like Katie's coloring book which is excellent, because you can make yourself all kinds of stories. I might as well start with that. We took the coloring book and did nothing more than just color the pictures and make up stories of my own. Here you can get a lot of things like when you are ill or when you are well and what happens when you are ill. Why you take drugs and that's where a lot of my thinking is flavored because of the fact that I have come into so many of the classrooms and the kids have said right away drugs are bad, we've got to get rid of drugs. You've got to understand that drugs have been here since man began so they're just not going to leave and if they were to leave we'd be in pretty bag shape so what we've got to do is learn to live with them and really do something for ourselves as learning how to use them. So I go through this with all different kinds of things so you can utilize some of these stories as decision making problems plus the fact that the bunny rabbit is looking at what he thinks is gum balls and he's not sure. This looks like medicine and some of these are really in bad shape now because I've colored so many different things. I allow the children to touch them and pass them around and all that sort of thing. What's he going to do about it and here again this business about asking questions and talking anddeciding what will you do. What should you do. He loves the gum ball and would like to have them. If he takes them he probably will get sick if they're not gum balls. Does he want to be sick. That's one of the big things trying to decide how you want to do your thinking of what drugs are for. In this case he has taken brother's medicine because it looked so terribly good. Brother came home with some cherrymedicine from the doctor and he thought it was pretty and it looked good so he decided he would try it. It wasn't meant for him because his brother was ill, he wasn't, and of course this is the way he feels at this point. Because he's taking something that really wasn't necessary for him. You can make your own stories. These are just some of the things I find and I'm completely out of context. I'll try to explain how we go as far as sequence. We develop some little sequence to our thinking. Each one of us works in kind of a different way because of four different personalities we have a set of objectives, we try to cover, but we do cover them in different ways because of our own backgrounds. He found this outside, he was playing and this is just one of the things children find very very frequently and it's surprising how often children will tell us they found needles or they found drugs outside. Then you've got the problem of how do you dispose of them. Some of the kids will say I picked it up, it looked pretty so I popped it into my mouth. Well, it's a very dangerous thing. The idea of thinking before you do all of these things and examining why. Sure a lot of our drugs are made up of sugar coating or look like M and M's, ju ju beads and other sorts of candy. The needles, so many kids find needles and they don't recognize the danger of all the diseases that can be transmitted because of that and this is another thing that we try to emphasize as to how you get rid of it, what do you do with it. We say take it in and give it to mom, get it off the street, put it down the toilet. Be sure its gone and the needles, putting them in a can or jar and putting in in the garbage. This one says "Well people who foolishly take drugs for fun can only become sick."

Participant:

Can you elaborate on your experiences of children finding needles and what they do with them.

Porter:

It's still something like the forbidden fruit, they see it, they wonder what it is, they wonder what it will do, who's had it and a lot of them have had experiences with Brothers and Sisters as far as shooting up. So they recognize it. Just this morning one little girl said "You know I almost made a real bad mkstake." We were talking about the fact of finding things and she went on to say she and a friend were at home and a brother or sister was mixing up a drug. It sounded as if he were mixing up heroin, morphine or one of them. She said it was in a liquid form but they were shooting it up. Whether it was speed or whatever I don't know but she said we went out into the kitchen and it looked awfully good and we were thinking of drinking it. It kind of looked like

Kool-aid. She Told me this before I even started the session. So it was said but they do dream up beautiful stories sometimes. You know you've just got to kind of m m m and you've got to take it for what it's worth. Sometimes if it's a very young child, doing something heroic is pretty big. It's surprising what you find in the streets. Children have brougt us some heroin. Then you get into marijuana papers and I mentioned something of paper coming in all different forms, chocolate, vanilla, strawberry and this sort of thing and one of the kids said I'll fix you up tomorrow Mrs. Porter" and the next day I looked I had rice paper, chocolate and strawberry and all different forms of paper so its available mostly because of older brothers and sisters. But there is an awful lot on the streets because people are careless in quantity. The papers that you wrap the marijuana come in flavors. Of course the papers are legal. Topps papers are a very big name and the children will go to the store and buy these. I've had a very good education believe me just by teaching. They buy the things. Borthers and sisters are using them. Sometimes mothers and fathers. This morning one of my children said her mom was using marijuana and I said carefully "She does?" "How can you prove something like that." The poor child was just sinking in her seat. I tried to show them that this is such a terrible accusation as far as just going around make this kind of accusation and I went on to talk about how some people think. One of the girls came in and said her uncle was using a needle and she said "I wonder if he is a junkey". So we talked about it and I said "Kind of ask your uncle" perhaps he's using it for some other reason maybe insulin. So it's just not something you go around and just mouth off about.

Participant:

How old are the children?

Joyce Porter:

we work with K-6 grade. This I use starting in Kindergarten and we're in the classrooms for 1/2 hour periods. The K-3 we see about 3 times, which is not enough but its a start. Hopefully the program will be expanded but this is also a big question mark. The others we see 4-5 times. Here again in 1/2 hour periods. We try to make a circle or something of that sort, so that we call can enter into it, try to tell them that they're welcome to ask questions at any time. We'll just talk about things. If you have ideas about something and you'd like to chime in that's fine and dandy. The teacher is invited into the circle, in fact she's not allowed to leave. That's one of the stipulations. We just say what we feel, not that we're good, just the fact that you can learn something from the questions on different subjects that we're going to reach you and you can very often learn something from the students. Usually they're shocked to put it mildly. The whole idea is what are drugs for and of course the idea of the draft, who feels terrible after the doctor has examined him and is going to give him medicine to make him well. That's a very important concept as far as I'm concerned. Drug as a drug we try to identify is something that makes you feel differently and makes you act differently. You come right down to it even an aspirin can be identified even in that way. You feel terrible and you have a headache, you take an aspirin because of the fact you are feeling badly and the aspirin will take away that headache. At one time we liked to identify pschoactive drugs in that way but really this is what it boils down to. I have to kind of hop and skip around. Do any of you people know Gramma Perrywinkle or the open ended story of Gramma Perrywinkle as far as the safety aspect of pretending, we do a lot of pretending. This is kind of a thing where we're trying to show that Gramma Perrywinkle is feeling badly. She of course has to go to see the doctor. A little boy or little girl will play out the part as we tell the story. We have a Gramma Perrywinkle and a granddaughter Jane, a doctor and a nurse and I usually use one of the teachers to be one or the other, a doctor and a pharmacist. What you're doing here is introducing all kinds of words. Then the concept eventually of safety. Gramma Perrywinkle is feeling badly and we make her go to the doctor. She gets her coat, her glasses and everything else and we can't forget her pocketbook. Eventually that's where she'll put her medicine. She goes off to see the doctor who examines her. All of them are acting this out and the children enjoy doing that. Then he gets a prescription from the doctor. The first word that you want to try and put some emphasis,on. You describe what a prescription really is and why its needed so she goes to see the pharmacist and he is a person who has a license to give out drugs. This is kind of a plot. So the pharmacist gives Grandma her medicine and types the label and puts his name on, which is very important. Eventually it comes to the fact that only grandma is supposed to take that medicine, the prescription medicine, comparison to an over the counter drug which of course anyone in the house can take depending on instructions. Then when she has it she puts it in her pocketbook and goes home. Granddaughter Jane meets her, happy to see her. She invites her in, takes her in the bedroom, she takes off her coat and grandma goes to get Jane some milk and she's gone, Jane gets into Grandma's pocketbook because she's looking for some chewing gum. She found something else. New we let the children finish the story. What will she do. Okay perhaps she'lltake the drug, because it looks like candy or because she thinks perhaps she should try it because it's Grandmas and usually Grandma has something very inviting. If she takes it how does it make her feel. How does it make Grandma feel.

What could she have done and then we go through all this process. Eventually it boils down to the event of the medicine chest which is really really worked. Kids love it. I let them touch it but its magical. If it gets too rowdy we juse close the door and then we've got to start all over again. I think its really important as far as letting them touch and see and really getting into the idea. Now there are lots of things left in medicine cabinets. In this particular one maybe your mother or father says to you to help yourself to the things in the medicine chest. A lot of parents have those rules. Okay fine and dandy but then you should know what you are getting and why. These drugs are things that can be used by everyone in the house but this one is a prescription medicine which is much stronger and is meant for just one person. On this one I've typed Grandma Perrywinkle's name and it says she can have 1 every 4 hours. I dont do all of these things at once, in other words depending on how many questions and how much they like to talk. I let them talk to some extent. Little ones always have a lot of stories to tell. I have puppets. I didn't bring all my things. I use puppets and we talk about feelings and why and what kinds of feelings we have. What happens to us and I use the two puppets. They talk to each other. They dl all kinds of things, show anger, show the feeling of being wanted and go into emotions to some degree as to two kinds of feelings, the kind where Mrs. Porter comes in the room and slams the door on her finger. It hurt. Mrs. Porter can look at her finger and say ouch it really hurt. I can point to the hurt, that's one kind. The other kind of hurt that's way deep inside and that shows up perhaps by crying or laughing or beating someone up. Some of these things we go into as far as the different way that we act and react to the different situations. I use a clown, not all these ideas are original.

Some of these you can find. Lou was going to bring some things along but I guess he forgot some of them. I'm not sure but I think Grandma is in the National Clearing House and she an old friend of ours. She was popular last year so we kind of resurrected her in different ways. I use a clown where I have a happy situation and a sad clown where I cut pictures out of the magazines. I cut out pictures of pills, alcohol and cigarettes. I use this with children in about second and third grade. Then Sloppy Joes and all kinds of things. Then you have to make up your mind as to where or when you take that object as to what it would make you feel like and how it would make you feel. You like Sloppy Joes so its going to make a smile come on your face. Now, I never say "No" because a lot of children will take a cigarette and they will put it in the smile. You've got to, why, why does it make you smile, why does it make you happy? Well it makes my mom and dad real happy. By the way we do bring cigarettes and the tobacco right in with the alcohol and everything else. It's just as strong, in fact in the second and third grade there's a great emphasis on this because this is something that they can associate with. There are reasons for giving it and then we talk about why alcohol makes people unhappy too. Why cigarettes? The fact that moms and dads very often would like to stop, but they don't know how and don't go into habits too deeply at this time. I go into habits a lot deeper later on as far as smoking is concerned. I'm goint to play with cans, the kids like it, it's using one of Vanish, one of Drano, and all kinds of things. The emphasis there is on household products which of course you must know a lot of these things that are sniffed, like Pam. Do you know that for a whilePam was a great big craz as far as shooting it up your nose and getting high from shooting. Gasoline hoppers. The kids that go up to the gasoline tanks and stick their noses over the gasoline hopper. The solvents, your cleaning fluids and things of that sort. You should be very aware of these things for your children. I didn't mention it but we do go into all the handicapped classes and we will talk to the teacher and find out how best we can approach them. The children who have sight problems, I let them sit real close to me and I let them touch everything, just moving a lot slower, depending on what kind of problem there is, but we do go into all of the classes. For your children this is very important because one of the teachers said to me that she had a child who had terrible headaches but she couldn't figure out and neither could anyone else why these headaches were coming on. Well this was before they put the additive into the airplane glue and the boy put together a lot of models which because of his sight he had the models right in front of his nose and so the poor child was sniffing glue. He was getting these terrible headaches and dizzy spells and nausea and all these kinds of things. So your handicap child is the one who may have accidents in this way. Also, the power of suggestion, a child, many children like the smell of gasoline. I think it's kind of good myself and they would go out and sniff around at the gasoline tanks, and cars, gasoline hoppers. I had one other experience with the handicap child this way. You should be aware of these things because very often they think there's nothing to this. A girl told me there was nothing wrong with this, absolutely nothing wrong. I asked her how she felt when she tried to explain to me what happened to her when she did this. We talked about it and eventually I tried to tell her what was happening inside her body which I feel is very very important. I think that we lose out real bad by not explaining to children what their bodies really are and how they work. We don't start early enough. We should start in kindergarten. We try not to criticize, we try to listen to the story and accept it as far as what the child tells you. You hear all kinds of stories. Brothers and sisters, it doesn't have to happen to the child itself, it can happen to the brothers and sisters. They're aware of it, they know what's going on and although they can't classify your drugs as being in the amphetamines, barbituates or hallucinative areas they know what it does to you and what's happening to their brothers and sisters. The vocabulary, it changes, it changes all the time and it changes from area to area and often times it's bard to keep up with it and I very ofter will just stop and ask the kid's what they mean by that because I really don't know. This is where like sneed creeps into the vocabulary and I never heard that one before for marijuana, so don't be ashamed admitting that you just don't know. The habit business. Trying to show them that some habits are good, you've got some good habits and you've got some bad habits. I drew one up for smoking and it kills some teachers when they have to sit there and listen t to it. In this corner is Mr. Tobacco. I use a lot of flip charts, by the way, I find them easy to relate to because the kids are watching something and I can watch them. Also it makes them think. They'll relate to something and perhaps that will bring on a question and I find it a lot easier to try to show them that drugs are not alien to us. The fact is that many of them come from plants. The marijuana being a week and the tobacco growing in the fields. People are making a living on this and one of the things they questions very highly is why? The living part, and also I always tell them "Ask your mom and dad, how they'd feel if tomorrow they couldn't get any cigarettes." Okay, mom and dad are hooked so to speak, they'd have a nicotine fit. What happens when they have a nicotine fit? So we go through the process of talking about the idea of your body, what happens when you take a drug into your body, how does it get into your body and I rely on that after the first lesson after I've identified what a drug is. The fact that sniffing and inhaling, where it goes, what happens to it.

Eventually, we come to the idea that whatever goes into is going to go through the entire body. I always tell them "You're beautiful" now that they're getting up in the higher grades. I wouldn't take this inot your K-1, sometimes the 2,3 because they're very much interested in themselves. Very often I follow through questions because of the fact you know kids are very much more sophisticated than others and they're asking more questions in depth. Then we talk about you, why you have blood, what happens with the blood as far as what it's doing there and we talk about what happens when drugs go into our body, why they effect different places and eventually of course in the 4th, 5th and 6th grades they're going to come up with the idea of the brain and that sort of thing. Then exploring why, why do people do these things and why do you want to do them. The idea being glamorous, in, cool. They're crazy aren't they, when I first started this I used to think this can't be. They seem to relate more to pictures and things and if I canact moredown to earth and stimulate their talking, we would get a lot farther as to really trying to discover why and what you want to do. Which eventually is the very last decision making. What a decision is, how you make decisions, sometimes making mistakes. Very often you make mistakes. Do I even make mistakes. What do you do when you make a mistake and then how do you correct it. The idea of when Mrs. Porter gets to be 91 years old and she's hobbling around on her cane, she's still going to have to make decisions. The idea of the age because very often children think that when you hit that magical age you're set, no more problems. Well you're all grown up. This is something my son did and at the time I thought the kids related to it really well. Who's in charge, who's leading whom around and then why. I think somebody mentioned earlier about the fact of the children being beaten. I tell the kids when we talk about alcohol and tobacco I don't just pull those things out. I say to them "Please tonight don't go home and throw away your mom's and dad's cigarettes" or tell dad he's a lush or be's a junky because he's drinks alcohol. This is something that each one of us has to decide for himself and when we get into alcohol we get into rules and why and the idea of tradition and all that sort of thing. Only that person who wants to stop can do it because a lot of times your kids hide your cigarettes or throw them out and they think they're doing you a favor and I think that's unfair to a child to send him home and perhaps he's having to take a beating because he's done something like that and we talk about the fact that habits being established early are harder to break because when you constantly put your elbows on the table your mother keeps yelling "Take your elbows off the table" so you take them off and they're off for a few minutes and they're back on again and mom is yelling again. This is a habit, so when you start to smoke very young this is very hard to break. And that's all I do as far as trying to show them that a habit is something that can go either way. You've got to recognize what it is. Now I've talked an awful lot. I can go on and on. Do you have any questions? Yes .

Participant:

Joyce Porter: No for some reason or not, not repore that's the one thing I'd like to have more time to work with them very definetely. Not repore no, it's so easy it seems because this is something that's part of life. This is life, really thats what it is, and when you get in there and sit, maybe even on the floor, I never take a teachers chair. I always take a small chair to be sure I'm on the same level and then just the idea of introducing myself and telling them who I am and saying I'm going to talk about medicines, then we get into the idea that medicines are drugs. Then also, one of the things I didn't show you, I use this with older kids the fact that you determine what a drug is to you. You determine it, nobody else. The drug is nothing more than a word. I always say to them

Joyce Porter: the drug is sitting there on the self, not one of them is going to jump down and grab you, this is not what is going to put your fingers on them and you decide how your going to use them. If you use them to make yourself well, if you use them to keep yourself well, then you call if medicine. However, if you decide your going to experiment, be curious then you have to know that these are the things that can happen to you. But you decide what happens to you, what happens to them, they don't decide what happens to you.

Participant: Will you share with us some of your experiences that you might of had using these visual aids in the mentally handicapped class. What type of response and what level you work with.

Joyce Porter: I didn;t do so much of that this year and I was thinking about it as I was sitting here tonite. Last year I did alot of it. So my memory is kind of rusty. The most important thing I remember doing is asking the teacher where the kids are kind of at as far as, have you had any converstations with these people as far as often times home life, what's happening, are there fathers alcoholics and that sort of thing. Then kind of just going in, this is probably the best opener of all just talking, taking it in. Not necessarily doing a story but I often times do one afterwards. Even with the really tall kids for some reason or other they really enjoy it. Lets pretend for awhile its kind of silly, all of us, and I usually assume the part of the pharmacist so that I can have a part of it to.

Participant: What ages have you done this with?

Joyce Porter: 12 and 13. Just because of the fact were all being kind of unusually silly.

Participant: Did it amaze you in terms of what they did know?

Joyce Porter: Yes. What I did was break the ice to as far as things that have happened to them. Things that they have seen. Ways that they feel about drugs. Some kids honestly feel truly scared, really scared.

Participant: What I have found with young adults at the Sigl Center, there was an interest there. I have approached our executive director and really through him, he said I don't think were ready for that we just got into sex education.

Joyce Porter: They should go together. They really should.

Participant: We get some booklets from the News Club on this. It was amazing the terminology that the kids know. I was thinking about how am I going to sit down and present this to the class. It was amazing how they have picked things up from the television. So many people are afraid in terms of exposing the handicapped child. We have a tendency to over protect, especially parents.

Joyce Porter: Not only the handicapped. Last year when we started the first thing that would happen was we were met at the door by a very anxious teacher saying what are you going to say. Don't tell my children anything please. One of my big tricks was to drop a word and kids picked it up and that was it. Once you show someone just a pair of lungs you say "how does a drug get into your body", the kids nine times of ten will say sniffing. The teacher will say oh. What do you sniff? So your really feeding from them and yet your not introducing it so to speak.

Participant: Do you consent your lessons outside of the school system, like to mothers?

Joyce Porter: Yes, I do sometimes. I've gone to different places. I'm going to have some of my things published. Some of the principals have asked if I would just get soem of the things together as that some of the

Joyce Porter: visuals could go out to some of the teachers and things. It's much harder to put it into written words then it is to show.

Participant: Can some of the things you left at our schools be found very helpful?

Joyce Porter: Yes. That was what we were suppose to bring along with psychological ideas and there from K-6 grades that you can utilize from different curriculums. The City School District wrote a curriculum last year and it hasn't been approved yet so to speak, and it's not in the hands yet but eventually it will be. But here again a curriculum is one thing, but dog gone it, we have to do all the work for this.

Participant: What kind of reactions have you had from parents in terms of exposing this to the mentally handicapped. Like how dare you bring that out.

Joyce Porter: People in general we get that reaction also a sigh of relief because many parents say I didn't know where to start. Teachers often times say it to. The other week I was in a classroom where a teacher said I really don't know where to start. That's another thing! If you don;t know the language your snowed the very first five minutes. Nine chances out of ten the child who's living that life because of brothers, sisters or family, he's going to hit you with all he knows and as a teacher who knows absolutely nothing about drugs he's going to hit you hard. He's going to bring them all out.

Participant: What recourse do you take if a child does bring a drug into you or if a brother or sister does use them.

Joyce Porter: I'll tell you that's hard. We have in the City School District rules to follow, places it has to go and it has to be reported. That's not too much of a problem. The only problem is that you have to make the child

Joyce Porter: understand that this is what you have to do with this particular drug that he gave you and you have to let his name be known. Of course, if he is telling you where it is coming from that has to also be known for the principle to be taken care of. We have a group of steps that have to be followed.

Participant: It must be more delicate to handle if it seems to be brother or sister but is there something done about it?

Joyce Porter: We can't really do anything. In fact thats a good questions. In one of the emotionally disturbed classes children got into a fight right while I was teaching because someone accused someones mother of pushing and she was a pusher. The girl admitted it and there's nothing you could really do. I would never do anything about it. It's just something that's here word against your word and all that kind of thing. Evidentally the child was no longer living with the mother, she was living with the grandmother and the teacher told me afterwards that this was one of the reasons she was taken out of the home. So it was known. This is a tickilish situation. You have to remember to about your children. Alot of your children will be on medication and that's important because they need it. That's my big thing. If you need a drug in order to keep yourself well and to make yourself well thats very, very important. You can get into all this business of how do you take care of it. Then also get into the alergic business. The fact that drugs that are taken sometimes make you ill. Because your body, being one of a kind, is different and special under yourself. Sometimes you can not take that particular drug. What are you going to do about it? Are you going to keep on doing it? The children always reply no I wouldn't keep on taking it. What are you going to do about it? Well I'll call the doctor, what are you going to tell him? The fact that drugs can also make you ill when your taking them to make you well. That can be kind of hard to get across to alot of mentally retarded children.

I've burned the marijuana tablet for the kids. I always tell them what you know and what you feel comfortable with is going to feel alot less inviting and so far as you will feel like one of the crowd if you can say yes I know what that smells is. Or I take the medicine chest along to the 4, 5 and 6th grade and soemetimes even the 3rd if they seem especially aware of what is going on. You work on Jefferson Avenue, School #4, right off Jefferson Avenue, School #29 there in the heart of heroin alley. Kids tell you about how people are seen. One day one of the kids came in and said this funny balloon they put the drugs in, then they swallowed it and when the police are gone they stick there finger down their throat. I said did you see that? Yeah, I saw that. So actually they live this kind of life. The other thing is the drop off point for heroin and all the different drugs. Its realistic. Its so prevalent, so easy to get. Don't fool yourself, your not protecting your child by letting them be innocent. I think your really making him more vulnerable to the idea.

Ken Weiner: Can I say one thing? I think that every once in awhile we have to remember that although our direct orientation is to handicapped children and handicapped youth, all through your history of dealing with the handicapped you know that damned little is put out with a specific crust. This is for the handicapped, very little. There just beginning now. The same is true with the drug scene but if you go in the basic premise generally that a kid is a kid then you can use all of the things people are saying modified to your needs. There might be a period of time were no one says the magic word handicapped, but think to yourselves how can I with the people that I am working with, with the people in my kind of handicapped be it emotional, mental, physical how can I use the things that they're saying. Can I kind of switch things around, chose some of the better things that there saying. Can I chose some of the better things that

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Ken Weiner: that I think I can use with my kids. Thats what we have to kind of do over and over again. Because there is nothing in this area that has been build specifically for handicapped kids. I think what this lady over there said is a very indication that that's what's happening with the handicapped. Don't tell them and then they won't know anything. Keep it a secret. Because they're handicapped kids and they're not as smart. As long as we keep it a secret from them we're fine. As she found out that's not the case.

Joyce Porter: If you are interested in some of these things they are available from Annette.
This one you can send for, it's thrity cents. This is the best as far as I'm concerned.

They went into two discussion groups to finish this session.

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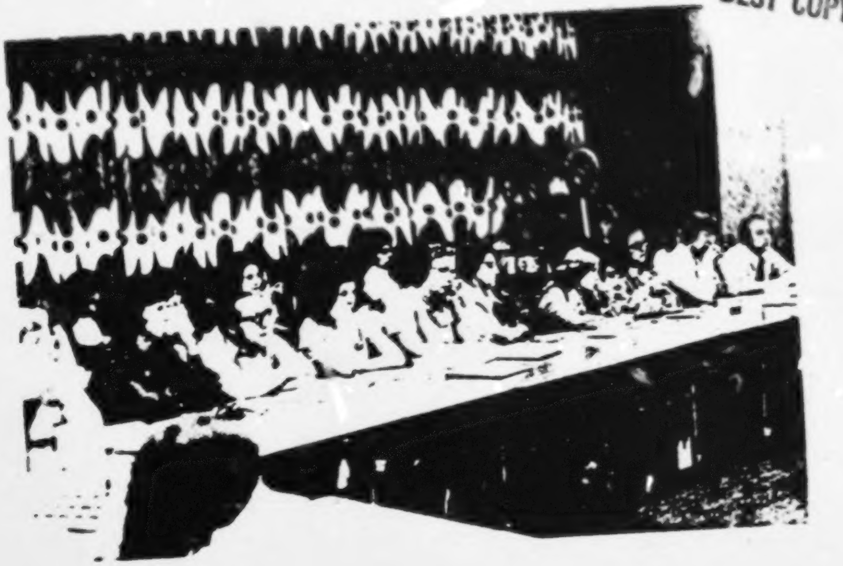

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SATURDAY, JUNE 2, 1973 SESSION

Lou Frasca

I'd like to make a few brief comments. When we were putting together this three day institute we were certainly concerned about the affective domain of drug education. What is cognitive drug information, drug knowledge misinformation, and etc? Mountains of literature, which is ineffective, if not actually harmful, that deals with that term, which we probably inappropriately call drug education. So as we talked about todays session, we thought about the kinds of things helpful to you, things you can take back to the classroom. A number of us think we are effective when dealing with people, dealing with their problems, one being drug abuse. But we're not.

I can't think of anyone I would rather have come than who we have selected to do a more effective job than the gentleman on my right, Dr. Marvin Levy. He would like to be called Marv Levy. He wouldn't give me a resume. I knew that. I asked when I saw and talked to him last. The reason why I think this will be an excellent experience for you is that last summer I spent part of a program with fourteen other people who are dealing with drug problems in school districts. That one week program to me, in my experience, was the most significant opportunity I've had to deal with what we are dealing with here. I've been through alot of junk, I guess most of it is junk. I think you will find this experience a very meaningful one.

Marv will introduce his people. Now alittle bit about Dr. Levy. I know he has been a part of a number of national programs in direction. He's on a number of counsels and a number of boards. He's not told me any of these things. I have picked them up here and there. He put this thing to-

Lou Frasca BEST COPY AVAILABLE

gether for the Department of Mental Health and the Association for Health Education. This is just a number of things. I could go on and on, but without saying any more....Marv Levy.....

Marv Levy

We're a group of people from Temple University in the Philadelphia area, that kind of bring together a variety of experiences in the field of drug education and what might be called or labeled affective education. There are some things we can do today that can have sort of a two fold purpose. One is be meaningful to you, something that can perhaps enrichen your lives in a very short span of time. Make you feel alittle bit better about yourselves so that you can relate better to others. Principally in your family, your children, as well as those you meet professionally. The other kind of thing we're hoping to do is that perhaps since we're not ny any means experts at all in the field of special education, which I understand most of you represent, we're not that conversal with the exceptionality and all the techniques which are associated with the special child in all of the special catgories. We do have a feeling about special education, however, the feeling is principally that speical education is good education for all for all children. It's rather unfortunate that some of the things people have been doing in special education haven't been done with other kids as well, because we think they are legally apliable to all kids. Secondly, that if we share something which perhaps directs you to or encourages you to seek out additional hints on strategies that can be used in the classroom with your own understanding of your own kind of kid would beable to modify those things to fit the learner that you come in contact with. You can do this far better than me.

I am associated with Temple University and I'm on the staff with Health, Education, Department of Health, Physical Education and Recreation. Alot of

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Marv Levy

people find it hard to imagine but believe it, it's the department I work in. With me are some people from Temple University and who will be leaving us shortly, unfortunately, I will miss them. A young man from Philadelphia who I met fairly recently who has, I think, a real interesting kind of experience to put you through, which he call the Power of Pretend. Let me introduce these people and tell you alittle bit about what is going to happen to you today. Let me start by saying that all that we do today with you, to you and for you as well as for us, because we get as much out of these experiences that why we do them. It's part of our own growth. We believe it's a process that goes on and on till the grave. It's important for us to become involved with groups such as this. All that we do is really voluntary and I'm usually a pretty honest guy, and Lou can vouch for this, I mean what I say. It's really voluntary, if there's something we do that you really prefer not doing and would prefer only to observe please feel free to do that. I don't want to force you into anything that's uncomfortable, or force you into anything you'd rather not do. Some of the things might be alittle strenuous, some of you might not want to get involved, that's okay you can sit and observe. We wont thing disparaging about you. We won't think your uncooperative. We can actually accept your preference. We do hope you will avail yourself to an many experiences that you would like to become involved in here. We have an all day session and it's a workshop. We're going to do very little talking although these is some talking involved. I understand from Lou you've already had the drugs. So we're not going to pursue that much for the drugs. I'm sure your all glad about that.

There's lots of materials up here that might perhaps help you in your understanding about drugs. If your interested, there are some things I'd like to point out among the things we did bring with us. Some books, if your really interested in understanding the relationship of human behavior and drug abuse, I would reccomend Oakly Roses book called Drug

Marv Levy

Society and Human Behavior. If you don't have a copy of it, I think it's an excellent sorce of reference, we use it as a basic text in our under graduate program for all university students. It's a popular course on campus, called Drugs and Contemporary Society. This is one of the texts that we use. I think it's one of the best books on this topic. We offer 13 sections of this every semester and they are almost always filled. As a matter of fact we're turning away because we only accept 30 people in the class. We believe in small class size. There's another book put out by the Consumers Union which I think is an excellent incavnation of drug fields. It's called Licit and Illicit Drugs. It's an excellent desk reference. If you belong to the Consumers Union you can get this for $4. It's a paperback, I'm not sure you can get the paperback without belonging to the Union, you might. The hardback is about $12.95 or something like that. If you can get the papberback copy it's the same as the hardback. It's much cheaper. This is an interesting little book, its sort of a dictionary, if you will, on drugs. It's an excellent resource as well. That you might like to add to your professional library. There are also things written by students, psycholigists. There are also things written by a hexachologist, farmachologist and educators. There are some suggested drug education cromchess. Some of the things that I think are pretty good, a young married couple both PHD's who are now working for the University of Maryland, have written two excellent books on drug education. Methods that perhaps some of you have seen, and I would personally endorse them. If you want to get an overview of the marijuana situation, I know many of you are concerned about that, perhaps now, Marijuana Paper by Solomon, there is a pretty good review of that. There are some books on alcohol, some things on smoking. There are some things put out by the National Clearning House of National Mental Health. There is little pamphlets here out of the Clearing House on drugs and there very well done. There is a series also

Marv Levy

specifically for the black student, and there here too. There are about eight or ten of those. So when you have time perhaps you would like to perouse these materials, I would do so, take any notes of things you would like to have and give them to Lou. Let me do some introducing.

On my right is George Lewsi. George for the last three years was a teaching associate at Temple University. Teaching Associates are usually young, at least if not chronically in spirit. Members of our staff who are working on their doctoral deagrees. George has been with us for three years. He's completed his requirements for his degree. He is finishing up his visitation. George has just accepted a job at Bridgewater as an assistant professor. We've spent three years with George and all of us benefited greatly, the faculty, the students and so on.

Lora Lang was an undergraduate with us at Temple, and came back as a graduates assistant, graduate assistants are masters candiddates who work in our teachers programs. As well as George being one of our supervising teachers he is very much in the aspective area. He's going to be doing some supervising modification wotk with you this afternoon. Lora is going to work with him in that area. Lora is finishing up a thesis with an advisor. It is an interesting project for the thesis that's she is doing. It does right to behavior modification. The thesis is done by modification. She is incidentally a member of a committee who is a co-author of a book which we will show you later this afternoon during second proble of behavior modification strategy.

Jake Keller is another one of our doctoral students. She has been a teacher associate with us.

This area of affective education deals with the broad concept of man. Barbara will also be doing some group things with you in the afternoon. We are going to split you into three groups. You will have an opportunity to be with each one of those groups. We will rotate and take turns in the

Marv Levy

the groups. The problem solving with Jake. Later to the Behavior Modification with Lora and George. Okay Jake why don't you start us off with The Four Dimensional Man.

Jake Keller

This is in the area of drugs as well as other decisions that have to be made. There is milk to drink, cars to drive or drugs to take. It requires an individual in our society to make a decision to do that. We will call him the decision making man. Throughout the day we will be considering some aspects of man to look at him in various ways. One of those aspects is the physcial man. The second is the intellectual the emotional or psychological man. And the Social man.

Specifically in this group there will be something this afternoon with Barb, the Metrical Curriculum. The aspects of the children you teach. Another variable that is very important in decision making is called valueing. That will also be dealt with this afternoon. This is a whole man or a dimensional man concept. Throughout the morning and the afternoon I hope you will have anopportunity to reflect back on this model.

Marv Levy

We're going to ask that you kids get to know each other alittle bit. So we're going to ask you to put away all your books and things and to clear your hands of everything. Many of you will feel much more comfortable for what we're going to do for about an hour. We'd also like you to take your shoes off. You've been together for a couple of days. I don't know how well you know each other. We're going to try to work on getting to know one another. You look at the whole demension through process. From its most simple form all the way to its most complex form. Principally we call ulandous 1/3 of the spectrum all the way through intensive group work that might be classfied more theraputic than educational. We're going to take

Marv Levy

you through the awareness part of it at least the one small aspect of that thats going to be dealing principally with getting to know each other. So we're going to do some of that. I quess I really ought to talk about the three dimentional man we're going to be working on today in particular. Let me give you alittle talk before we start working.

I'm trying to make you very relaxed. The four dimentions Jake put on the board, I have a fifth dimention for it. I think it sort of surrounds the other four dimensions, the spiritual dimention of man. I think the man whether you are an advocate of some particular organized religion or perhaps are searching for some basic truths in life or perhaps searching for a quest for something lasting. We all have that need. As a matter of fact related drugs we find out that many people are looking for some absolutes about life. One of the needs that seems to be frustrated in people is the fact that they have not been able to relate to that dimension. Organized religion, obviously, has been around for many years. Organized religion as some of you know, through a period of change, probably more so in the last ten years than ever in its history. This change has been rather significant in there attempt to involve the layman in the spiritual life. Many organized religions have made changes even to allow woman as of the clergy. Some religions are just getting to it while others have been into it for awhile. The thing that always interested me about the drug abuse scene in regard to the spiritual man is the fact that those who begin to find their spiritual selves begin to find that they have less needs for other kinds of external mechanisms to satisfy that need. Through out history man has searched for the spiritual dimension through chemicals. In fact its still done today. The Indians for example in this country are the only group that are allowed to use illegal drugs legally. As part of their religion, and religious experiences they have used illegal drugs. I guess Tim Leary in away and people like Allen Cohen, who use to be Budda Priest

Marv Levy

also used drugs in this way, and did find away to relate to a mystical experience. What some people have come to realize is that chemicals are really not necessary to have mystical experiences. One of the things that religions are moving towards is finding away of providing that excess to the spiritual life without chemicals are really not necessary to have mystical experiences. One of the things that religions are moving towards is finding away to provide that excess to the spiritual life without the chemicals. Probably the most darmatic example was the Jesus movement in Californai where young people most of whom were heavily involved in drugs, without and medication, intoxication or therapy course have found in the spiritual life, away of getting off the drug habit and find true spiritual experiences out of there own power in relating to Jesus. Thats not uncommon some teen chanllenge, for example, that has an spiritual approach for example. In fact AA really started out as a spiritual approach. If you look at AA the most important thing is to find that power to help the individual to help his own drinking problem. It isn't necessarily new but its an important one. I think we ought to be able to think faithfully and experience the spiritual man.

What I find is the one sense that we rely on most often is the sense of our sight. We forget our other senses. It's rather important because we tend to almost forget the other senses in our body. The touch and taste and smell. The sense of sound itself. Sometimes we have to begin to teach people to use those senses in away they can find real fullfillment. Some of the things that we're going to do are really the physical dimension. The sensory experience I quess was demonstrated to me in the Ashbury area some years ago when the teeny bopper problem they had with speed and methodrine situation, you probably have heard of that, one thing that amazed me while watching kids using speed or shouting speed was particularly the description of the experience while there undergoing it. The kinds of words they used

Marv Levy

while describing it. Like turn off, white light, white rush are all very sensory kinds of terms. They are physical sensory terms. It seems to me they were trying to get orgasmically high.

Drugs can become very much an orgasmic experience. A drug addict, maybe a year or so ago, described shooting heroin to me and he described it in terms of a physical sexual experience, which he got through his use of heroin.

One of the things we hope you will begin to understand about drug users are that they often times have great sexual inadequecies, particularly relating to himself. Sexual inadquecies or experiences, if you will, are fullfilled through these chemicals. In other words, it's not the best way to do it. But as this man described it to me, as a matter of fact, if we did more of the other we'd have less drug problems. He talked about his own use of heroin and he described it almost as a sexual response experience. Remember the stages of sexual response, excitement and so on. That's what he did with heroin. When he rolled up his sleeve, that was like undressing, exposing his veins, his body, his organs, if you will, that was sort of the excitement phase; when he was preparing his fix, when he was putting his heroin into water and disolving it, filtering it through his cheese cloth into his eye dropper that was also getting ready and that was part of his excitement phase. Now he's about to inject the spike into his arm he was at the plateau stage, beginning to get ready for the orgasim. The experience in his arm when he plunged his thumb on the niple on the top of the eye dropper to inject the heroin into his arm; when the heroin hit his blood stream it was an orgasim. It was the rush of orgasim. He felt it orgasmically throughout his whole body as one would do in a sexual experience. When he pulled the needle out it was like the resolution stage just wanting to go to sleep after a good sexual experience. He described it principally that way. When he got a good look at his own sexual behavior we found out that he was

Marv Levy

actually capable of sexual behavior. This is true of most people.

One girl said to me in my office one day, she was a student at Temple incidently. I asked he about shouting speed, she was doing it at the time when she was having problems with her grades. What was it really like? She said it was like fucking myself in the arm. That's how she described it, it was for her own sexual experience.

The intellectual dimension you can't say to much about, other than I have never met a junky, a hard core heroin user who was not extremely bright. Not to say that they may have been very good in school. They might have been a low achiever but they had the ability to use that brain of theirs effectively. As a matter of fact, if they did not have that ability they would not have survived as a junky on the street. The junky on the street has to be very bright. Only bright people know how to manipulate others. One of the life styles of an heroin attic is to know how to manipulate other people. Manipulate their mother, their wife, their children and manipulate the forces on the street and for them thats an easy task. If any of you have been exposed to ex-drug addicts one of the things that amazes lots of us, particularly any children that get exposed to them, if you bring in a junky to give there life experience talk, as they do which I don't recommend to an assembly program, one of the things kids hear are very intellegent people who may have been a junky for 15 years or 10 years or eight years who sounds alot smarter than any of the parents. They got that way using heroin, so whats wrong with using heroin. So they are basically very bright people.

The emotional and social dimension I'm going to talk about won't particularly be involved. I'll talk about the social dimension first. A couple of anthropologists decided to study the relationship of drug abuse to social phenonemum. What happened in culture where drug problems seem to exist? They had to isolate two chemicals that they could study because the two

Marv Levy

chemicals happen to be chemicals that have been used for a long period of time in cultures as the cultures went up and down. Different kinds of social conditions that they were exposed to. They found that alcohol, a drug, was used as far back as early man. Well, you can imagine that it was the first drug discovered by man. Primative man, probably before he discovered the wheel or maybe fire, lived in the cave where he was exposed to alot of pressures. The caveman was cold, the cave was damp, it was dark and lerking outside that cave was a flesh eating Allasaurus. Alot of threats, alot of discomforts of life. He happened to find quite by accident a bowl of grapes, that he forgot about in that clay pot he had somewhere in the back of his cave. He took a sip of it after it had sat there for many months. It sort of bubbled up, he took a sip of it, one sip and all of a sudden the cave became less damp. Two sips and the cave became less dark. It sort of lit up alittle bit. He took three sips and its probably warmed up too. If he took enough of it, five or six perhaps, he got up enough courage to pick up that little stone axe and go outside and kick the hell out of the Allasaurus. Drugs have done that to man. To deal with his anxieties. So the anthropologists were interested in alcohol because its the oldest drug. Go into the earliets papers. The reefers of the early Egyptians, they have alcohol in most of their remedy medicines. I'm going to talk about three variabled that the anthropologists studied when they looked at alcohol, they also looked at peyote which is also a drug of old abuse. Peyote grows in a cactus plant. It also grows in this country. I'm sure you've heard of mescoline. It's a very common drug. The only problem with it is that it is very hard to synthisize. It is very expernsive and there is no mescoline on the street. At Jefferson Medical College the last three years they have been analyzing street drugs from Writtenhouse Square in Philadelphia. They've come up with about forty samples of mescoline. In the Baltimore area they came up with 58 samples of mescoline. Did you talk about this earlier?

Participant

No, are they all acids?

Marv Levy

Most of it is acid. In fact one out of 58 found in Maryland was acutally mescoline. One in Philadelphia of forty was mescoline. 90% of it is acid. But there is 10% which is an extremely dangerous drug. I think in many ways more dangerous than LSD. That is PCP. I don't know if you've heard about it. Have they talked about it in the workshop? It is a drug you ought to be familiar with. It is an animal anestetic. It is veternarian medicine. It was used as a mild kind of a seditive drug and a mild tranquilizer too. In medical practice in a short period of time they found very undesirable side effects and it went off the market for human consumption. Because it did produce hallucinations in human subjects so obviously the production of hallucinations was a nice kind of thing. It was a little brown tablet, it was called mescoline because it did produce hallucinations. That is what they are getting principally.

Let me talk about the three vaiables. The first variable that they found that was linked to the drug use was the variable identified as the extent of inner tension within the society. I'm not going to spend alot of time on this. What they found out was that the inner tension, the state of anziety in a society was high when the drug use was high. When the state of inner tension was relatively low the actual extent of drug use in that same culture was the same, availability of drugs was very low it almost patterned the social conditions of anxiety of people in that culture experienced. When we think of todays modern world, this country is living in a very tense world. There is a tremendous state of inner tension, infact, when I look at the state of inner tension in this country today I'm more likely to ask not how come so many people are using drugs, but if the anthropologist is right how come so few people are using drugs.

Marv Levy

The second area that they found linked with drug use or correlated with it or significantly was the attitudes in the culture of drug use particularly about the drug of your choice of course in our country we have a wide choice in the use of drugs. What they found out is the attitudes of societies profess in actually the aid in concert with linked to the rate of drug use. But found it dipping about the attitudes that they found out about attitudes is that very personal attitudes in society permissive attitudes we say to say to everyone you know drugs are here so it is part of nature when it isn't. Or, do your own thing. Societies that have that kind of attitudes have high drug use. On the other end of the continuin, societies which say drugs are bad, use them and were going to chop your head off, or we'll lock you up for 5 years for processing one joint, those societies also had high rates in drug use. Both extremes have high reates of drug use. Think for a moment of our own experiences in this country, an example is prohibition, remember last 14 years we passed the act. What happened in this country, the purpose of prohibition was to reduce the use of drugs, unfortunately that objective was never reached because from the experience we learned more people used alcohol than they were using i before the passing of the law, in fact, it created a social tabou, it seemed to attract certain segments of society, perhaps you remember that experience, I know my parents did particularly. We're invited to take that chance, to try that excitement, you know going to the speakeasies. And drug use sort, alcohol sort that increased 10% in 14 years which was a significant increase. Also, it introduces women to hard liguor before they had not had much of a problem with hard liguor. They say those who forget the past are doomed to repeat it. I think we ought to take a look at what we're doing in our own society. About our laws as a reflection of our attitudes on one hand we're saying don't use drugs. And if you do we're going to really make it tough for you. But on the other end of the continuin we seem to be practicing the

Marv Levy

the other extreme. The Food and Drug Administration are studying the medical use of over the counter drugs, the medicine cabinet drugs. They found twenty two to the average family, twnety two over the counter drugs really dangerous in there households. People were popping diet pills, these which have no relationship with loss of weight, you know the amphetamines is said to be not a good drug to use to lose weight. If it is used it should never be used more than six weeks. Also, used in treatment of narcoepsy, the desease of not being able to stay awake. The other one of course is the hyperactive child and I guess you did get a talk about that so I won't dwell to much on that. But our attitudes, we have nine million alcoholics in this country. In fact, if you look at the total drug abuse in this country, drug addicts, if you will, they are those people over 30 years old not the young people in this country. Those are the people that make up a large portion of people who are abusing drugs. That is where our attitudes are, both extremes. If you look at that you may understand why we have a drug problem today. Because we have laws which are quite repressive. On the other hand we have a demonstrated attitude of our own use of drugs which say it is kind of alright. Look at the commercials on television, what they are saying to us in this uptight world there is no reason why anybody should experience pain. We have a methologically advanced society. Chemicals of all kinds can kill physical pain, headaches; upset stomachs; back pains, you name it. When the Madiosn people realized that there are more pains than physical pains, as early man discovered, socialogical pain, they started to use those same type of drugs to help the emtional needs. What they began to say is remember the pain killer aspirin? They came right out and said don't use theirs use ours because it is twice as strong as theirs. The rope appeared on the screen and the tube and the rope got tighter and tighter, remember the words on the screen it wasn't headache anymore. What was the word? It was tension, a psychological term.

Marv Levy

If you took two of theirs, remember what happened? Like magic the rope mended itself together and became slack. Now that kind of sticks in our head. Or the commercial where everyone is going to get a headache pretty soon so before you do take two aspirins, remember that commerical? Or the office where at the end of the day they dump a whole jar of alka seltzer in the water cooler. The people come up with there little paper cups and it takes care of all their problems. I forgot to mail the bosses letter today, I put the wrong check in the envelope. It even took care of love, one guy in that commercial was trying to make that real shapely secretary, he takes his drink of alka seltzer and its amazing she actually notices him. Then they ran out of pschological discomfort. Remember the one that won the emmy for the best TV commercial. It was an alka seltzer commerical, they have won many by the way. They invented a new desease to take care of this drug. Your head rolled off. You took these two little things that fizzed in the cup and all of a sudden you'd put your head back on. The desease was called the blahs. Then another company came along and they hired Casey Stengles, he was making all these speeches where they always served cold chicken and wringled peas, and he said people don't wait for those two things to dissolve because you could be drinking this while those two are still in your stomach. Why do you think a kid gets convinced to stop smoking pot and to try something else because they have been set up for it.

The thrid dimension is alternatives. What they found out is that the society where there is fewer alternatives to deal with tensions but drugs were there they went to drugs. But the society where there were lots of ways of feeling good, lots of things to do, lots of ways of getting your orgasmic experiences or commuting with nature and your spiritual self drugs were used less. This is something I hope we can work on because that is what affective educations going to be about. That search for alternatives and ways of feeling good. In fact I used to spend alot of time talking to

Marv Levy

kids about smoking pot and the thing I used to do was tell them that pot was no good and I used to ask them why do you smoke it and they said because it makes me feel good. I keep saying well it really doesn't make you feel good. It does all these terrible things. But I didn't realize what people perceive is real to them and if they felt that it made them feel good, in effect it made them feel good. So it was a total waste of time. The it occurred to me that maybe there was another approach. I can except the fact that smoking pot makes you feel good, grass can do that. That is not the issue. What it is, really is why do you have to smoke pot to make you feel good. What is making you feel bad? Now, when you can get at that dimension then you can begin to make a change if that is what your really interested in doing. If all of us felt really good enough, and if the schools can look for other ways to get kids into themselves to grow in these dimensions that we're talking about today.

At this point the large group had an experience called "Power of Pretend" led by Dr. Claude Nolte.

The larger group then broke into three small rotating groups which had sessions on sensitivity, behavior modification, and values clarification.

VALUES CLARIFICATION

Seven Valuing Processes

Choosing:
1. Choosing freely--choosing of your own free will rather than being pressured or as force of habit.
2. Choosing from alternatives--choosing after examining all of the possible alternatives.
3. Choosing after consideration of the consequences--choosing after thoughtfully considering the consequence of each alternative.

Prizing:
4. Prizing and cherishing--being proud of and happy with your choice.
5. Affirming--being willing to publicly affirm your choice.

Acting:
6. Acting--acting upon your choice so that it affects your behavior.
7. Acting repeatedly--doing something about your choice many differnt times so that it becomes a part of your life pattern.

Some Areas of Values Conflict and Confusion

Money
Friendship
Love and Sex
Religion and morals
Leisure Time
Politics and social organization
Work
Family
Environment
Character development
Education
War

Guidelines For Using The Values Clarfication Strategies

1. Try at all times to refrain from moralizing. This includes making judgements either verbally or non-verbally of student responses and "loading" values questions in favor of your own value.
2. Work toward building a feeling of trust in the classroom. Three important ways of helping to build this feeling require that moralizing be kept to a minimum, no reporting of student responses to "outsiders" (counselors, parents, the principal, other teachers, etc.) and no use of values lessons or work as part of the students grade.
3. Start with simple, brief strategies which require students to invest a little of themselves and more to strategies which are more personal and require more exposure of self thus involving more risk as a trusting, open climate develops in the classroom.
4. Particpate in the strategies yourself whenever possible.

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*Strategies can be found in Values Clarification: A Handbook of Strategies, by Simon, Howe, and Kirschenbaum, Hart Publishing Co., New York 1972. $3.95. For further reading on the values clarification theory, additional strategies, and many suggestions for classroom use, consult Values and Teaching: Working With Values in the Classroom, by Rathe, Harmin, and Simon, Charles E. Merrill Books, Columbus, Ohio, 1966. $3.95.

DRUG ABUSE EDUCATION: A PEDAGOGICAL SCHIZOPHRENIA

- Marvin R. Levy

Over a year ago I attended the Annual Meeting of the American Public Health Association in Philadelphia. I arrived early for one of the section meetings devoted to drug abuse education. As I waited in the almost empty room, three worried matrons wandered in and asked whether this was the right place for the lecture on schizophrenia. Interpreting their query literally I said "No." But perhaps I was in error. For surely the issue of drug abuse education as a panacea for our drug oriented culture reflects a formidable mass schizophrenia - the split between those who view only the negative, unhealthy, dangerous side and those who believe that drugs serve very constructive useful and satisfying purposes. Or the society that on one hand supports mass media inundated with drug commercial sophisms, eulogizing products for physical, emotional, and social discomforts or as a means to escape or relieve the constant daily stresses and strains on our minds and bodies, while on the other hand antihedonistically condemns those who use drugs in search of pleasure and satisfaction. Or the over thrity segment of society who produces approxiamtely 4 billion amphetamine tablets each year (half of which gets into illicit distribution channels for social and private use), who uses over one million pounds of tranquilizers and 50 million barbituate prescription, who has about 9 million alcoholics (among a population of 200 million), and whose medicine cabinets contain some thirty medications of which 80 percent were purchased over-the-counter without a prescription, while condemning young people for using "illegal" drugs. Or a society that claims to be concerned about our inadequate care, high infant mortality rates, hunger and malnutrition, a rising crime rate, rat infested inner city slums, racial tensions, campus unrest, an ever increasingly polluted environment, and in general human suffering and waste of human resources while supporting a was in Indochina costing up to 20 billion dollars a year that is less than eagerly supported by many Americans. This scarcely credible breach between our society's permissive - even obsessive behavior and attitudes and the verbal pronouncements against drug abuse reflect our split personality. When one stops to study the hypocrisy of our behavior in terms of our pronounced values, and the extent of inner tensions posed by contemporary living coupled with an ever shrinking set of alternatives to cope with them, one is less likely to ask why so many of our young people have turned to drugs but rather ponder the riddle, Why have so few become involved?

Dr. Ole Sands of "Schools for the Sixties" fame in recent paper presented at the National Research Conference on School Health Education stated that the Greeks were remembered by historians for the rubric of liberty, the Romans for law, the English for parliamentary government, and perhaps historians will label American culture in terms of universal education. He may well be right.

Education is commonly perceived as a means for attaining a better life and the school is considered to be one of the important socializing institutions in our society. It's influence has been placed second only to that of the family.

In portraying the transformation of the school educational historians characterize the school as the reflection of the prevailing hopes, aspirations and fears of society.

More recently, the American public has expected, more it has demanded, that school develop strategies to overcome the influences of the environment that impinge upon approved behavioral norms including variations in the family. When acceptable psychomotor responses are not developed by the family, society turns to the schools for their transmutation. Hence the schools are looked upon as a shield against a legion of social problems and a palliative for deviant practices. A further consequence, therefore, has been the attempt to ameliorate behavior of this magnitude by some modification of the school curriculum. The quintessential innovation in response to a crises oriented public has been "add a course."

Since there has been an increasing concern about youthful drug involvement, demands were renewed for more drug education. This is much the same reaction for more sceince programs when Sputnick cast its shadow upon some of American education.

We, in education, have high hopes for knowledge as a way of guiding productive lives. It is therefore important, it seems to me, if we are to emphasize fact-finding skills in the school setting that students be helped to synthesize them into a rationale for the direction of group norms and personal values.

Although it seems reasonable to presume that information on the hazards of drug abuse would reduce the likelihood of experimentation or actual dependency the truth of the matter is that if scientific knowledge alone could keep people from abusing drugs we would not have the comparatively high level of drug abuse among members of the medical professions. Furthermore, the knowledge of drugs and the level of sophistication about drug abuse among young people who have become involved in the drug scene is generally higher than their non-drug-using peers. What is needed then?

Two sociologists at San Jose State College viewed the role of the school as one of making the educational experience relevant to the lives and personal problems of students. Commenting on relevancy in education, a noted psychiatrist wrote:

> As parents, citizens, and teachers, we need to act together to upgrade education and keep it relevant to each of youth's three big tasks: (1) learning our cultural heritage of values and knowledge, (2) becoming persons in their own rights, and (3) finding the courage and understanding to cope with the problems their generation will meet...the best deterrent to drug abuse is education that strengthens an individual's code of values and increases his ability to assess the consequences.

In a recent assessment of drug education programs operating under the National Drug Education Training Program, the kinds of techniques which seemed to be effective in reducing existing drug abuse were:

1) utilization of young people at all levels of planning and implementation.
2) emphasizing human relationships as much as drug information.
3) use of small discussion groups.
4) self-evaluation in which participants identify their won weaknesses and attitudes.
5) utilization of older youths working with younger ones
6) presentation of factual information rather than scare techniques.

The techniques which were believed to be especially harmful or ineffective included:

1) scare tactics.
2) indiscriminate use of former addicts.
3) use of programmed materials without emphasizing the human aspect of the problem.
4) use of the all-school assembly or large group sessions.
5) use of numerous or long lectures without time for meaningful interaction.

Dr. Louis G. Richards presented a useful taxonomy of educational techniques in drug education.

1. Scare tactics
2. Authority
3. Logical exhortation
4. New cognitive information
5. Self appraisal and attitude confrontation
6. Status enhancement
7. Novelty, humor, and drama

The problem with selecting appropriate techniques lies with the abysmal lack of empirical research and scientific invetigat on regarding the effectiveness of these techniques in changing subsequent behavior.

In spite of the lack of cogent directions for these approaches the drug abuse education, it may be helpful to consider the effectiveness in these techniques in other settings and to, then consider their feasibility in drug abuse education.

Scare tactics-this approach is based on the belief that the recall of negative reinforcement will lead to abstinence. It has been severely criticized in many quarters of education as grossly ineffective. Janis & Feshback long ago established that scare tactics were less effective in changing practices than a more neutral approach.

Why is scaring them so ineffective? Fear produces anxiety. Anxiety intensifies already existing anxieties, feelings of inadequacy and failure, frustration and lack of self-esteem. In a few days the message dims. The anxiety engendered penetrates into the subconcious and intesifies the need th escape, to feel strong instead of weak, to find artificial means of dealing with the problems of living. Fortunately, the majority of students exposed to such method of education will not be adversely affected. However, the borderline susceptible may find just enough to want to see "how it feels." When one feels inadequate to deal with the pressures of living, knowledge presented in such an authoritarian manner could actually have the reverse effect and act as an enticement.

Psychological studies demonstrate that when a person has strongly held beliefs and attitudes, they are rarely changed by a one-sided, aggressive attack on them. The studies indicate that a more balanced approach which, instead of attacking a person's beliefs, guides him to reassess them himself, holds more promise. In other words, educational effort which directs itself toward facts should present both sides fairly and attempt to stimulate the student to make appropriate decisions in an intelligent and responsible manner.

Dr. Seymour Holleck suggests that since young people do a great deal of reading about drugs they can embarrass someone who "oversells" the drug effect and find it easy and amusing to expose the moralistic basis of their remarks. Once these biases and ignorance are exposed by the more sophisticated students, the other students will snicker and respond to such a technique with an attitude of supercilious resignation.

A concomitant scare tactic is to base the program upon the legal issue "it's against the law." Dr. Helen Nowlis reminds us that too many high school students are caught up in the issue of personal freedom, civil rights, individual liberty, and react adversely to leagalistic dictums. In the spirit of bolting against the legislation of personal decisions, the students may be forced to the uncompromising position of defending an action he otherwise would consider as inappropriate in dealing with resolved conflicts. It is similarly unwise to attempt to support the law with scientific evidence. It may in the final analysis defeat the underlying meaningful issue it was designed to buttress.

Authority-this technique uses some recognized authority for their expert opinion in order to convince an audience of the validity of the message. Since there are many kinds of authorities on drugs and since the public is rather confused about drugs today, physicians, psychologists, sociologists, lawyers, judges, law enforcement officials, clergymen and ex-addicts are utilized in such programs. Studies such as one done in Michigan seem to indicate that high school students want advice on the health aspects of drugs rather than on the moral or legal implications. These students rated physicians highest drug users near the median, and policemen, ministers, and school counselors at the lower end of the scale. In a classroom instruction experiment in Los Angeles students in the experimental schools (those using ex-addicts) scored significantly higher in both knowledge gain and attitude differentiation about drugs and drug users. Apparently, ex-addicts lent credibility few teachers could have provided however, the probability of a double-edged phenomenon is high (some students might have seen drug addicition as the means to a desirable end since the addicts are often articulate, bright, and healthy looking young adults acting in a prestigeful role).

Both of these biased approaches (scare and authority) seem unlikely to have a positive influence upon young people over an extended period of time.

Logical exhortation-this technique is based on the theory that documentation will provide new points of view. It attempts to provide pros and cons so as to enable the learner to make decisions from some logical basis. There is some evidence that knowledge increases and attitudes change in this approach. It is still too early however, to completely endorse such a technique since it has only been demonstrated on a fairly sophisticated audience.

New Cognitive Information-this technique attempts to convey drug knowledge to students in a conceptual approach so that students will be better able to draw on these concepts in making decisions. Although not primarily persuasive in design, the approach attempts to move students toward moderation or abstinence. The expectation is that students will gradually attain the desired concepts and easily acquire a great deal of factual knowledge which can be used in the later development of new concepts. The belief is that teaching which focuses on behavior, rather than content, is far more conductive to the internalization of basic concepts. These approaches use behavioral objectives as expectations for the student as the result of instruction.

Although these long-range outcomes are stated in behavioral terms, only carefully conducted longitudinal studies will give some idea as to their effectiveness in achieving these aims.

Self-appraisal and attitude confrontation-this technique was borrowed from a therapeutic and rehabilitation model. The principle rests upon the belief that for many, attitudes toward drugs are closely related to one's feelings and self-concept. It is an attempt to attack drug abuse at its roots, within the individual. The techniques are group precesses (i.e. encounter, attitudinal confrontation, communication, problem-solving, cooperation, and rap sessions).

Although this has caught the fancy of many innovative programs, evidence of success to encourage this approach is not all in. However, I think we can say with reasonable assurance that the extent to which we can build self-esteem, that we can help children face reality, and that we can nourish the development of self in concourse with others, will do much to prevent the need for drugs.

Status enhancement-this technique focuses on providing students with facts that they, in turn, will transmit to peers or younger students. The rationale for this approach is that motivation to learn increases with the responsibility to convey the information to others. A project in Coronado, California has students search out facts on drugs and then convey what they had learned to their peers. A similar approach was developed by Mr. Ray Kaufman, presently with the Diagnostic and Rehabilitation Center in Philadelphia, Pa. He trained a number of high school students at Gratz High School in drug education. They in turn are communicating what they learned to junior high school students. Both of these programs resemble the approach used by Mr. Jack Gross of the College of Pharmaceutical Science at Columbia University, N.Y. This project was called RFD (Respect for Drugs). It involved the training of local pharmacists who went out and conducted similar sessions for community groups.

Anyone who has been involved in teaching knows that the best way to learn anything is to be required to teach it to others. Such programs have met with a good deal of success and appear to be effective in increasing knowledge and changing attitudes.

Novelty, humor, and drama-this approach focuses on entertainment techniques in which the teacher attempts to dramatize the decision-making process through films, theatrical plays, and sociodramas. First the quality of these materials particularly on drugs, varies considerably. Some take the sociological approach, warning against the loss of income, status, dignity, even freedom attendant upon abuse. Some are purely descriptive of drugs and their effects. Some show in great detail the ways drugs can be used, other maintain a studiously clinical distance. Some project a tone of moral outrage while others a tone of cool scientific detachment. None of these will give audiences identical trips.

I am somewhat wary of this approach however, there are some basic rules that if followed improve chances of success.

1) Don't trust any technique solely because someone else recommends it. Preview it yourself.

2) Don't trust even a well designed program to contain only accurate information
3) Don't trust one expert-consult several. It would be preferable to preview the material with a few teachers and students whose opinion and reactions will be helpful.
4) Provide for ample time to process the activity such as a discussion period following the presentation. This might contribute more to the desired objectives than the activity itself.
5) Keep audience small. In intimate groups, comments and criticisms come more freely and there is opportunity to correct errors, misunderstandings, and inaccurate inferences.

What Else Is Needed

In order to present an instructional program which does more than dispense facts, the total educational setting must be tuned in to the needs of young people. The emphasis should always be upon an examination of decision making in such a way that the student becomes more aware of the factors that influence his decisions and resultant behavior. There needs to be ways for students who are identified with problems or who feel as though they have some concern to gethelp. This may necessitate an ongoing relationship between the school and other community agencies with the kinds of staff, skills, experience, and resources to deal effectively with the problems of young people. Therefore, just the development of a new curriculum for young people is worthless unless other parts such as adult education, a Help-Line or Hot Line (a 24 hour crises intervention telephone service), youth centers, informal rap groups, and counseling services for students and their parents, are also planned for and implemented.

Dr. Seymour L. Halleck, professor of psychiatry at the University of Wisconsin and Director of its Student Psychiatric Services believes that educational programs can be of some help to young people if they focused on the broader social and ethical issues. He claims that the best explanation for the growing use of drugs in this country is that we are an unhappy society. And, our young people seem especially desparate. In order for drug education problems to be helpful to young people, Dr. Halleck feels that they must be "supported by a firm commitment to examine and deal with the more basic causes of human despair."

"Children tend to become like people they perceive, like the people they experience and psychologically consume-the people their teachers are."

The exempler role of adult behavior is of vital significance: we cannot disregard its importance and fail to behave in a positive and constructive way if children are to grow to become positive people. Without a commitment of courageous social act on, the character and personality of young people will fail to be strengthened. Unless we begin to work together in building a more humane world the conditions which spawn drug abuse will thrive.

> "The thing that counts is us. Subject matter, organizations and evaluative techniques are all important, but the major perceptual stuff for a child is other people. In education, the other people are the adults who work in school."

It may seem strange that such a statement needs to be highlighted, but highlighted it must be against the background of teaching-learning, childrearing practices, in vogue. The objective for any educational program must begin to give students not information but dignity, not facts but respect. To the extent that a school can do this, students will become a little closer to the realities of living and a lot less searching for a bedrugged escape.

Dr. Gilbert M. Shimmel of Columbia University describes the need poetically:

> To love and be loved; may feel loved
> Are man's most primal needs,
> Without which, deep within his soul
> Will sprout the evil seeds
> Of lonely pain, anger and fear
> Which blossom soon or late
> As violence and misery
> And slef-destructive hate.

This is what drug abuse is all about. The schools can help by recognizing that a child is not born loving or hateful. These are learned. Teachers and parents need to learn to use themselves to teach young people to learn to love and thereby build self-esteem.

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PEER GROUP APPROACH TO DRUG EDUCATION

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ABSTRACT

Since our drug raid during the fall of 1969 and the present application of the peer group approach much has been explored concerning the changing of attitudes and behavior. The complexities of the learning process, including the student, methodology and materials, must be re-examined.

Drugs are not the problem. Finding ways to communicate so that the student has a chance to involve himself actively in the learning process in the secret. An active exchange of honest information will, in the long run, provide more lasting impact.

Many approaches to solving the drug problem are being tried. The main advantage of the peer group approach is that we are involving students to help us with a mutual problem. The realization that students are an untapped resource to help society influence others is the hope of the seventies.

We should start with the Woodstock Festival which was held within the confines of our school district in the summer of 1969. As the publicity indicated, we had approximately 500,000 people in this area. The facilities at Woodstock itself were not adequate and with Monticello only 10 miles away, much of the overflow was in our community.

In terms of parental attitudes, many were convinced that this poor example, or this example, depending upon whether you think it is poor or good, would influence our students with the thoughts of using more drugs. Many identified the long hair, bell bottoms, and acid rock with pot. This was the attitude; whether it was true or not was not important. The point was we had the attitude developing.

We opened school in September and during the fall we had a drug raid. I think the fact that this followed the Woodstock Festival really got the people apprehensive. Many of the citizens were upset at the thought of drug users among our students.

Seven concerned parents approached our Board of Education with the question of what was going to be done about the problem. As a result of this, a meeting was called two weeks later for the sole purpose of discussing the drug problem. A cross-section of representation of our community was invited - police officials, the district attorney, clergy, doctos, parents, students, narcotic guidance council members, teachers, administrators and school board members. The reason for this meeting was to involve the total community in an attempt to formulate meaningful guidelines and to set up a dialogue so that each group would understand the others' position. Perhaps this was one of the most important things we did. At the outset, we made it a community problem, not a school problem. This meeting is a must for any community contemplating a drug education program. I'll admit that it is a hard way to approach a problem because of the different methods of approaching this kind of conflict. The overriding thing that tied people together was that everyone wanted to solve or gain new insights into the drug problem.

Following this meeting, Dr. Charles W. Rudiger, Monticello's Superintendent of Schools, asked me to represent the school in all community activities concerning this area. I was already a member of the Monticello Narcotic Guidance Council and a school administrator so the school-community approach was built into my administration from the beginning. Both the Monticello Narcotic Guidance Council and the Monticello Board of Education agreed that before we implemented any approach we would evaluate all past approaches and research any new proposals in depth. Many of our past approaches were not effective to the degree we wanted, so repeating these procedures obviously was not the answer.

Past Approaches for Solution

I think that we should review briefly, here, the approaches used in the past years. None of these observations should in themselves indicate that we are completely opposed to any of these approaches. We are simply saying that these one shot panic approaches do not solve the problem. In 1966 we brought a law enforcement official into our school. He addressed our high school students along the lines of "if you use drugs, you will be arrested...if you are arrested it will be on your record...if it is on your record, you will have problems later on in life getting a job." He tried to approach it from the point of view that you are simply breaking the law. The students were not in favor of breaking the law but the motivation of breaking the law was not going to stop them from using drugs.

The whole format of expecting a law enforcement officer to address 1000 students and make an impact was wrong from the very beginning. The students sat there passively, some asked questions for the sole purpose of entertaining the student body. The law enforcement officer has a definite role in drug abuse but this role is not to come in as a teacher; I defy most teachers to handle that large a group. The only purpose this served was that the school could say they were doing something about the drug problem; we put an article in the paper that said so. At the time we were sincere; we believed it ourselves. We thought maybe this was the approach. At the same time we had a total health program but the emphasis on drug education was very minimal, to say the least.

In 1967 we thought we would solve the problem by bringing in former addicts. When the former addict comes in, he makes a presentation concerning his life story, some of the problems he encountered along the way, some of the possibilities of why he went on drugs. He then goes on to say why it is foolish to get started on drugs and that the life style is not the way to live. He generally is very articulate and makes a very good presentation but sometimes the effects on the student body are reversed. He has been in the drug scene and he is articulate, speaks well, and so forth. Some students say maybe it is not such a bad thing... maybe the drugs have opened up his mind like a lot of people claim. Some immature kids in every group role play as they watch and want to be a former addict someday. They think this is a great thing to do, like an evangelist type concept. I think the former addicts' role is primarily in rehabilitation. In fact, I think most former addicts will admit this. I don't think they belong in a massive health and drug education program. And again, for similar reasons as the law enforcement officer, it was unfair to the addicts to expect them to reach students in this type of atmosphere. This wasn't the way used for rehabilitation so why would this method be attempted for prevention.

In 1968 we waited breathlessly for the latest films on drugs. The acting wasn't exactly academy award status. The clothing that the girls wore was not the latest style and the music in the background was not the latest hit record. Some of the scenes, especially where a person couldn't get heroin, became comical for some of the kids. For others it became a sickening scene, especially when they put needles into the arm, and so forth. One school had two girls get nauseous and two vomit. Another school had eight girls get nauseous and five vomit. Obviously they had a better drug education program, based on this fear concept. Scare them to death with the film, and maybe they won't go on drugs. No opportunity for dialogue, the students sat there passively. This wasn't good education.

In 1969 we solved the problem by having a spectacular! We had the law enforcement officer, the former addicts, clergy, film, and so forth all on the stage at the same time. We showed the film, then had a panel discussion following, and for 45 minutes experts sat on the stage and argued with each other. The students again did not get overly involved in dialogue; again, we were attacking only the symptoms of the problem, we were only talking about the surface and we never really went into depth to analyze why people use drugs. To be perfectly honest, all these presentations, generally speaking, made alcohol sound like it was great and marijuana was bad. At that time with that argument you turned about 75 percent of the kids off before the program started.

New Methods Toward Solution

Presenting these programs as a background our task was now to formulate new methods of attacking the problem as a supplement to our health course. Of course, we have a formal health course for the middle students and a formal health course for the high school students. We have integrated health into the disciplines of the high school and integrated health in the elementary curriculum K through 5. Obviously, this by itself was not the answer. We had to do something additional to supplement it, something with impact. It had to be on a show business plane; it had to be something that really had a dynamic presentation behind it. So we evaluated all things that we had done and all new methods. We spoke to officials of the State Education Department and the Narcotics Addiction Control Commission. At the time, in 1969, the best thing that we could come up with was that we would have five workshops in our community based on pharmacology, drugs, legal problems, education methods, audio-visual aids, etc. We would have 60 adults trained by five experts in their respective fields in the problem of drug use and abuse. This seemed like maybe not the best way to approach the problem, but perhaps the only available new thing on the horizon.

Background to the Peer Group Approach

What we did in Monticello was a little different than what was done in some communities. This was really the start of the peer group approach. We involved 20 high school students in the workshops. Instead of having 60 adults, we had 40 adults and 20 students. How did we get the 20 students? I went to the class presidents for grades 9 through 12. Since the class presidents were elected by their class, I asked each president to pick four students,representing a cross-section of his class, that would like to be involved in these workshops. The main criteria for selection would be a good personality, liking to talk, and relating to people. I think it important that we emphasize this concept because this is the first step in the peer group approach. I did not pick the students; the class presidents were elected and the class presidents picked them. These students were not to be known as the establishment's boys and were not going to be called narcos by the student body. They had to be picked by their own peers, not by the organization.

The first night we had 20 students, 40 adults, and the speaker in the room. The speaker spoke about pharmacology and drugs the first hour, the second hour was primarily questions and answers. I can remember one of the adults saying

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that one of the kids - bearded, long hair, bell bottoms and beads - was probably on pot himself. In reply, the student said, "Listen Mister, you can't solve the Viet Nam War, you can't solve the poverty problems we don't like your priorities..." At that moment the so-called, and I emphasize so-called, generation gap came forward. Of course, the generation gap doesn't really exist, it is really a communication gap. So, on that night at the end of our first workshops, we thought we had another fiasco (because the adults and students were together...maybe this was not the approach).

But we continued with the workshops, primarily because we had scheduled them. By the third or fourth workshop a beautiful thing happened. It seemed to be shared by adults and students and they were making inroads into each other's feelings. The adults were suddenly saying nice things like, "My God, he really cares, the one with the beads and bell bottoms, he thinks, he can feel, he can love, he wants to be involved, he wants to make the world a better place to live." And, the students were not quite as ciritical of the adults. There are so many external forces that can't be controlled in society, you can't be held responsible for everything that happens in your family every moment.

By the end of the five workshops, there were 60 *people*, not 40 adults and 20 students. I had 60 people that all shared the workshops, had a common bond and in some cases showed affection for each other. In fact, there was one adult and one student in particular who established a new relationship. This is very important to emphasize because I would never train students without adults. Without the benefit of the adult dialogue with the students you lose so much. It would be like trying to train kids in a vacuum. They might as well be trained in an atmosphere where questions are asked in which they can share. The only gap we have is a communication gap and if we communicate enough we can eliminate that problem.

We completed the five workshops and decided to have three more for the students. We talked about group dynamics, group interaction, psychology, how to answer a question, and how to be honest about being unable to answer questions. If you are going to use students to talk to other students some guidelines are needed. This is a very controversial area and you just can't let students talk to other students without some safeguards. Peer students must be completely honest and their answers must be based on scientific research. We provided our students with two books, *Answers to the Most Frequently Asked Questions About Drug Abuse* and *Drugs of Abuse*. Both these books are published by the U.S. Government Printing Office. The reason I liked them was they were both factual and excellent as resource books for my peer group students.

If you are asked a question that you can't answer, don't feel threatened, don't feel that you have lost some confidence; just simply say, "I can't answer the question." When we used the peer group approach this statement helped establish rapport. Kids related better with other kids who said they didn't know everything. As adults and teachers, we must stop telling half truths to save ourselves because we lose credibility with students. When you lose credibility in a drug education program, you might just as well not have one. Credibility and honesty are the main inputs in a drug education program.

Now that we had trained the students for the eight workshops, they had some confidence and knowledge in the health and drug education area. The next problem was what we could do with these 20 students. Would they go out and talk to their fellow classmates, in the high school, formally or informally, or what? We sat down and discussed this very democratically. Where do we go from here? The consensus of opinion was that the kids would feel more confident if they worked with younger students. They weren't quite as sophisticated and perhaps they weren't already using drugs. Teachers go to college for four to five years to gain confidence in expressing themselves and we can't expect high school students to have this kind of confidence after eight training sessions. Of course, they have enthusiasm and a desire to be involved in their world, which overcomes most other considerations.

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The students decided that they would like to start with the 6th grade kids. I felt that the attitude development of 6th graders was still in the formative stage; maybe we could still reach them before they got to high school. If we wait to do a drug education program for juniors and seniors we might as well not have one.

I am not saying that you can't do anything in high school, but it is a lot harder. So, we started in the 5th grade with this program. I went to the middle school principal and said that I would like to start a pilot project with thirty 6th graders. The middle school principal designated a cross-sectional representation with 15 students in one room, 15 in another room. We asked the 20 peer group students to elect four students from their group. Now we had two peer group students with fifteen 6th grade students in one room and two peer group students with fifteen 6th graders in the other room. We asked the teacher not to be involved in the program or in the room during this session. We felt the teacher would make the high school student a little nervous and that the 6th grade students would not open up quite as much as they would without the teacher. This brings up a supervision problem but we felt that we were in the building, the superintendent was in the building at the same time, the middle school principal and I were there, and it was worth the risk from the supervisory point of view. At this point I think we should define the peer group approach.

The Peer Group Approach

The peer group approach is based on the fact that the students are very much influenced by their peers. As an example, let me tell the story of the little girl leaving home in the morning wearing a skirt a little too short. Her father and mother are very upset. They tell their daughter that they want the skirt a little longer. The girl is very upset because she wants to please her girl friends and boy friends (peer pressure is unbelievable). Peer pressure is so unbelievable that I used to see students get off the bus with one outfit and an hour later change to a different outfit; they had another outfit in their lockers. This illustrates the lengths that kids will go to please each other as opposed to pleasing their parents.

Kids don't have a monopoly on peer pressures. Part of our problem is that adults have gone to all kinds of lengths to compete with each other - homes, cars, vacations, etc. We can't say that there is something wrong with the students because they are peer oriented; we are all peer oriented. Interestingly, this same peer pressure that may cause students to go on drugs may also cause them not to go on drugs. As I think back to my days as a high school student, middle school student, and junior high student, I can recall myself looking up to the high school students and wanting to wear a sweater with a letter like the ones they had, wanting to comb my hair like the football players, imitating their life style. I think that middle school students are very much impressed with high school students. When they say something it means more than when an adult says the same thing. The adults seem to be preaching; where the high school student is saying it like it is. Sometimes the middle school student will buy that.

The new approach was based on the exchange of information, facts debated, group involvement and scenes between students where honesty and concern guided the confrontation. Students who actively deal with their peers in a mature manner while in a group situation will, in the long run, develop more lasting attitudes toward the drug scene. They are more concerned with what their peers think about drugs than with what adults think. Drugs are abused for different reasons: for group acceptance, to socialize, experiment with and, in some cases, to escape reality. These reasons are the same reasons we use for alcohol: for group acceptance, for socializing, in some cases to experiment, and in some cases to escape reality. The was basically the philosophy behind the peer group approach.

Going back to the fifteen 6th graders in one room and the two high school students - this was our pilot project - and before we allowed thirty 6th graders to participate, the middle school principal sent slips home to all the parents asking them for permission for their child to be involved in this project. We had everything cleared; the administration and the board were aware of what we were going to do. We kept no secrets from the press. They were invited to observe - not in the room, but to look in the doors and talk to the students before and after. If this thing failed it would have done so in a big way just like everything else had failed. But we had a little confidence in the approach plus it served another purpose. We involved the high school students in their world. They want to be involved and here is a positive way to involve them. As we find more ways to involve high school students in their world, this in itself is a drug education prevention program. In fact, that may be more important than anything else we have done.

I was about to learn my next lesson; at the time I didn't know it was happening. We had the thirty 6th graders and the two high school students divided equally in two rooms. We then decided to go for 80 minutes. Why 80 minutes? We figured the kids would be interested and it proved to be right. In fact, we could have gone for 160 minutes. Once we got started the problem was to keep the kids quiet because they were so enthused. You have to visualize this if you will, My high school students had their amphetamine, barbituate, and heroin literature ready and they were pretty up to date on drug information. They had a drug display case plus all kinds of motivational devices to get the kids started. One of the very first questions asked was how do you make the cheerleading squad. Other questions were aksed regarding senior high honor society rules as opposed to middle school senior honor society rules. Questions and observations were made about parents that they would not say at home. All kinds of things started to come forth.

At the time it might not have been related to drug education but we were actually discovering another lesson - you can't talk about drugs in a vacuum. You have to relate it to life - you have to relate it to health, total health; of course total health is life. My high school students rose to the occasion. They answered the questions the kids asked establishing a rapport. Then, when they wanted to start talking about drug education, the students were much more ready for it because they had first talked about other things. You just can't talk about drugs out of context. If you want to approach a drug education program by itself you lose from the very beginning. You have to approach it from a total point of view, examining all inputs.

At the end of the 80 minute session we took the four high school students into a room with a tape recorder. No one was in the room except the four students. I asked them to record everything they could think of that happened in those rooms. We needed this kind of information for an evaluation. We did not want them to mention the names of any students who said they had a brother or sister using drugs. This was not a police interrogation. This was an evaluation of the program.

We had to have something to decide if we were going to go from the pilot to the full 6th grade. So the next morning we played the tape to the Superintendent of Schools, the Middle School Principal, community representatives that were involved in our program from the beginning and the four high school students. Based on the tape and the students' evaluation and some of the teachers that had feedback in the middle school, we decided to work with the whole 6th grade. You have to remember that at the time we were doing this, it wasn't being done anyplace else and we were very, very concerned all through it. We took our time, we went slowly. We found from our own observations that we made some inroads and had presented more credible information that the students could relate to than any other methods we had tried.

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John T. Lawler

Peer Group Approach to Drug Education

Does It Work?

I have to say I am not sure this method works. It appears to work. This year, 1970-71, we have a built-in evaluation. We have two different people designing test instruments. These people are nationally known and they are designing pre- and post-test procedures to measure attitude and behavioral change. Of course, the input to these students is not the peer group approach by itself. It is a total health program supplemented by the peer group approach. A peer group approach can't replace a total health program. That again would be a misunderstanding; this supplements a total health program.

For purposes of review, and to mention other factors, I would like to list ten reasons why past approaches have failed.

1. They were based on inaccurate information.

2 Lack of community involvement. Here I think it is important for a school not to attack this problem by itself. Involve all of the community. In fact, I think we have got to start involving the community in all the things we do.

3. The past problems were based on knowledge impact instead of attitudinal and behavioral change.

4. Students were not involved in planning and helping present programs. Research has indicated that when you are part of a target group and involved in the planning you are much more receptive to the presentation.

5. The emphasis was on scare techniques and sensationalism. Scare techniques don't seem to be working. I think it is like trying to scare people into driving slowly. You might better tell them how to drive properly. I think the same thing is true in drug education. Tell them how to live properly, don't try to scare them to death with needles.

6. Lack of methods for measuring sophistication of students. I think we had better start finding out what these students really know before we start our programs; to assume they will know something is a mistake. A simple inventory test will tell you whether they understand the terminology they are throwing around.

7. A one-shot or panic approach not a total health approach. I blame this primarily on school administrators. They put on a program for the primary purpose of saying to the public they are doing something about drugs. Anyone who has any experience in drug education knows that the one-shot approach is a waste of time. In fact, that one-shot approach with no pre-planning and no follow-up might do more harm.

8. Lack of measurable objectives.

9. Failure to understand that drug abuse is a part of a total attitudinal and value change for example communications, pill society drug culture, affluence poverty, priorities establishment war. I think if you sit down with the students and discuss these issues, the attitude develops on both sides and again emphasizes that there is no generation gap, only a communication gap. We have forgotten how to listen. I have to say listen four times. LISTEN, LISTEN, LISTEN, LISTEN, because as a parent and educator I have retrained myself to listen to what someone is saying to me, especially my own children. I think communication in the home is of utmost importance and a lot of us do a lot of talking but we don't do very much listening.

10. We were relying on experts in the drug field instead of the total community resource. I found that I have many resources available in Monticello. I think they are untapped. They always were there but no one took the trouble to find them. This problem can be solved with all of us trying to humanize education and trying to humanize our world. Maybe it is a case of different priorities, short range and long range, but it certainly isn't going to be solved by bringing in some expert from 150 miles away to give a two-hour lecture on how to solve the problem. He can give guidelines and he can give help, but the follow-up and presentation must be done locally.

As a result of this program, and this is only part of the program, Monticello Central School is now a pilot school for the New York State Education Department.

Listed below are the methods presently being used at Monticello Central School. After two years of intensive experience in health and drug education we have developed the following goals, objectives and methodology.

GOALS

To increase the amount and degree of interpersonal relationships and communications among and between members of the total community, i.e., students, parents, teachers, etc.

OBJECTIVES

To develop positive attitudes and knowledge with respect to the use and abuse of drugs, including alcohol and tobacco.

METHODS

1. Involve all community resources in determining the seriousness of the problem and possible solutions.
2. Involve students in planning and presenting programs to students and adults.
3. Emphasize honesty and concern as opposed to scare techniques.
4. Recognize that peer pressure is a strong motivational device.
5. Make drug education part of an ongoing health education program.
6. Have students and adults attend workshops on an equal basis.
7. Do not involve former addicts in mass school prevention programs.
8. Emphasize drug use and drug abuse.
9. Recognize that alcohol and tobacco are drugs.
10. Integrate health and drug education into all educational disciplines.
11. Maintain in-service health and drug education for adults, students and teachers.
12. Place special emphasis on mental health and relationship to world problems.
13. Attempt to reach 5th,6th,7th, and 8th grade students and teachers.
14. Evaluate pre- and post-testing, measuring knowledge, attitude, and behavior.
15. Use resources of local and state narcotics control commissions, and education departments.
16. Involve students and adults together for mutual attitude development.

The prevention of drug abuse is the main thrust of this program. This article mentions only partially some of our observations at Monticello. Our method may work at Monticello but we do not pretend to have all the answers. There are no experts on drug abuse and each community must find its own approach. The purpose of this information is to help you design your program realizing that we are in the process of evaluating ours.

This year we are administering test instruments to measure attitudes and behavior change. One was designed by Dr. Carl Chambers, Director of Research, N.Y.S. Narcotic Addiction Control Commission, and one by Jurgen Karker of the New York State Education Department. Hopefully, this spring we will have some outside analysis of the impact of our program.

Inroads are being made. Once you understand that drugs are not the problem, that the problem concerns many, many factors besides the pill, and once you utilize the resources that are available, you will have a positive outlook. We can solve this problem...we will solve this problem...we are going to rise to the occasion and the kids are goin to rise to the occasion. Most kids, and I say this sincerely, want a better world and want a little help in getting that better world. They want us and I think we want them. If we look at it any other way, it is self-defeating. I am not overly optimistic, and I know that it is not that easy. Everything I have described took months and months of thinking and doing to come to any conclusions.

Also, a special thank you must be given to Dr. Charles W. Rudiger, Superintendent of School who created an educational environment in which innovative programs are encouraged and supported.

The Board of Education gave this program top priority and requested information at every meeting. Eighteen months later drug education is still on the Board's agenda. I must emphasize that the Superintendent and Board of Education are completely committed to solving the drug abuse problem.

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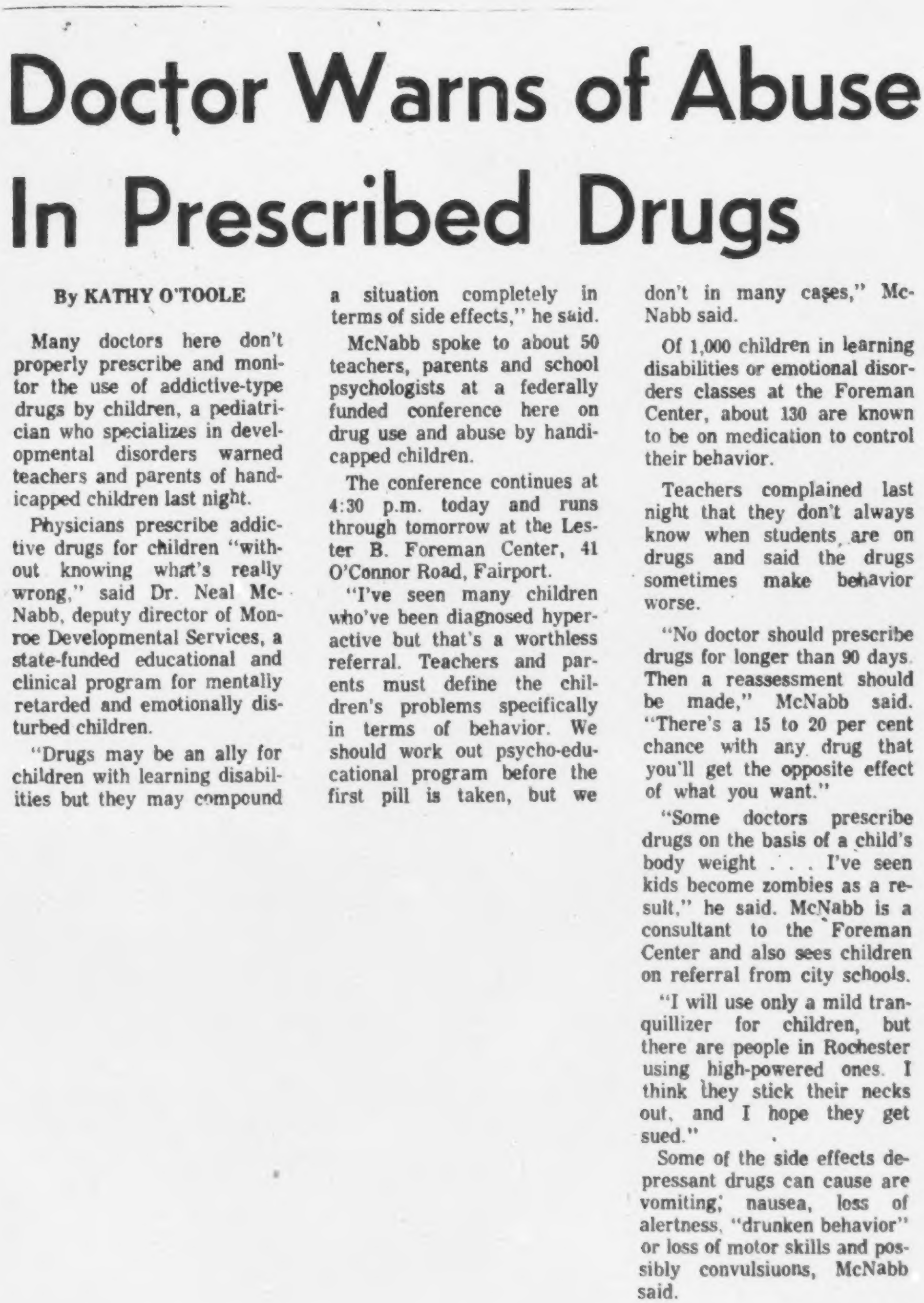

Doctor Warns of Abuse In Prescribed Drugs

By KATHY O'TOOLE

Many doctors here don't properly prescribe and monitor the use of addictive-type drugs by children, a pediatrician who specializes in developmental disorders warned teachers and parents of handicapped children last night.

Physicians prescribe addictive drugs for children "without knowing what's really wrong," said Dr. Neal McNabb, deputy director of Monroe Developmental Services, a state-funded educational and clinical program for mentally retarded and emotionally disturbed children.

"Drugs may be an ally for children with learning disabilities but they may compound a situation completely in terms of side effects," he said.

McNabb spoke to about 50 teachers, parents and school psychologists at a federally funded conference here on drug use and abuse by handicapped children.

The conference continues at 4:30 p.m. today and runs through tomorrow at the Lester B. Foreman Center, 41 O'Connor Road, Fairport.

"I've seen many children who've been diagnosed hyperactive but that's a worthless referral. Teachers and parents must define the children's problems specifically in terms of behavior. We should work out psycho-educational program before the first pill is taken, but we don't in many cases," McNabb said.

Of 1,000 children in learning disabilities or emotional disorders classes at the Foreman Center, about 130 are known to be on medication to control their behavior.

Teachers complained last night that they don't always know when students are on drugs and said the drugs sometimes make behavior worse.

"No doctor should prescribe drugs for longer than 90 days. Then a reassessment should be made," McNabb said. "There's a 15 to 20 per cent chance with any drug that you'll get the opposite effect of what you want."

"Some doctors prescribe drugs on the basis of a child's body weight . . . I've seen kids become zombies as a result," he said. McNabb is a consultant to the Foreman Center and also sees children on referral from city schools.

"I will use only a mild tranquillizer for children, but there are people in Rochester using high-powered ones. I think they stick their necks out, and I hope they get sued."

Some of the side effects depressant drugs can cause are vomiting, nausea, loss of alertness, "drunken behavior" or loss of motor skills and possibly convulsiuons, McNabb said.

PRE-POST TEST

"Drugs and the Handicapped Child" Institute

Name Composite

We are faced with making decisions daily. Check any item under each statement that would best describe your course of action in a given situation. More than one item may be checked.

What does a teacher do when she is faced with a drug problem student in her class?

		PRE	POST
______	Contact police	0%	2%
______	Contact parents	40%	44%
______	Talk to student	82%	82%
______	Send student to dean	14%	41%
______	Send to guidance counsellor	25%	29%
______	Send to psychologist	20%	8%
______	Send to social worker	17%	8%
______	Nothing	0%	0%
______	Talk to rest of class but ignore user	2%	2%
______	Not sure what to do	17%	2%

How does a teacher react to a student who informs her he has just overdosed on his maintenance drugs. (i.e. Ritalin)

______	Contact the principal	62%	76%
______	Do nothing	0%	0%
______	Call an ambulance	22%	17%
______	Try to contact student's doctor	68%	55%
______	Call parents	40%	50%
______	Ask student why	8%	17%
______	Send to dean	2%	5%
______	Send to social worker	0%	2%
______	Not sure what to do	8%	0%

How does a teacher react to a student who informs her he has forgotten to take his maintenance drug. (i.e. Ritalin)

______	Do nothing	0%	0%
______	Watch for abnormal behavior	54%	55%
______	Call parents	60%	67%
______	Send to dean	2%	14%
______	Send to social worker	0%	0%
______	Call an ambulance	2%	5%
______	Try to contact student's doctor	28%	47%
______	Not sure what to do	2%	2%
______	Contact principal	40%	35%

How does a teacher accept the responsibility of administering a maintenance drug.

	PRE	POST
______ Should not under any circumstances	45%	14%
______ Only with written parent consent	40%	58%
______ Only with written doctors consent	45%	91%
______ Only with written consent of principal	14%	29%
______ On students say so	0%	0%
______ On nurses say so	0%	11%
______ Not sure what to do	2%	2%

You have a student on a maintenance drug. You have observed him before and after he has taken his prescribed dosage. On the average how do you anticipate his behavior will change.

______ Becomes more manageable	65%	61%
______ Becomes hyperactive	0%	2%
______ Quiets down	31%	32%
______ Falls asleep	2%	0%
______ Becomes incoherent	2%	11%
______ Gets better grades	17%	20%
______ Improves perception both visual and auditory		
______ No noticeable change in behavior	25%	20%
______ Attention span will increase	25%	41%
______ Attention span will decrease	2%	5%
______ Not sure	22%	14%

You have entered a girls room and smell something that you think is marijuana. There are three girls present. You should

______ Do nothing	2%	0%
______ Call principal	62%	70%
______ Call police	0%	0%
______ Call parents	8%	14%
______ Talk to class	11%	20%
______ Talk only to girls present	71%	76%
______ Not sure	5%	2%

A teacher should be aware of the following resources concerned with the drug problem.

______ None	2%	0%
______ The Center	60%	100%
______ Crisis Control at Strong	62%	70%
______ Narcotics Commission	40%	47%
______ Rochester Mental Health Center	65%	79%
______ Vice Squad	11%	17%
______ The SPCC	8%	14%
______ Drug and Alcohol Commission	42%	58%
______ Hospital Emergency Room	42%	50%
______ Not sure	20%	2%

You have discovered a student of yours is on drugs

		PRE	POST
______	He will refuse to discuss it	17%	17%
______	He will discuss it generally	5%	14%
______	He will discuss it specifically	2%	8%
______	He will more likely discuss it in a group situation	17%	23%
______	He will admit it to you but no one else	8%	41%
______	He will expect you to keep his problem confidential	62%	61%
______	Not sure	40%	8%

Teachers can best be made aware of all the aspects of drugs and drug abuse by

		PRE	POST
______	Literature	57%	50%
______	College classes	22%	23%
______	Inservice classes	85%	85%
______	Institutes such as this	88%	94%
______	Classroom experience	37%	20%
______	First hand experience	28%	44%
______	Visiting clinical situations	40%	35%
______	Not necessary for teacher to be that aware	2%	2%

A student of yours is on probation. His probation officer has made an appointment with you. You should prepare for this by

		PRE	POST
______	Talk to student	42%	58%
______	Talk to principal	40%	38%
______	Talk of parents	22%	29%
______	Talk to social worker	40%	35%
______	Talk to psychologist	34%	32%
______	Talk to school district legal counsel	14%	14%
______	Rely on own judgement	34%	35%
______	Refuse to talk to probation officer	0%	0%
______	Not sure	14%	5%

You have heard of a great drug film available to you. You should

		PRE	POST
______	Show it immediately	0%	0%
______	Preview it to determine its value	80%	97%
______	Show it at the most opportune time	14%	14%
______	Show it selectively to a few at a time	8%	11%
______	Preview it-show it-discuss it	62%	44%
______	Alert all other teachers to film	37%	20%
______	Don't bother with it since you didn't order it	0%	2%
______	Not sure	2%	2%

Composite

"DRUGS AND THE HANDICAPPED CHILD"

Institute Evaluation

Check the number from 1 to 5 that best describes how you feel concerning each session below.

1 = ineffective or boring
2 = somewhat interesting but not that useful
3 = useable
4 = interesting, useful and valuable
5 = very helpful, full of ideas, very interesting, a must for educators

1. The institute as a whole.

1_____ 2_____ 3_____ 4 17% 5 83%

2. An overview of the drug scene.

1_____ 2 13% 3 13% 4 44% 5 27%

3. The medical aspects of drugs.

1_____ 2 11% 3 11% 4 27% 5 50%

4. The legal aspects of drugs.

1 2% 2 14% 3 16% 4 4/2% 5 22%

5. The human development area of Drug Education.

1_____ 2 5% 3 11% 4 30% 5 52%

6. The Center.

1_____ 2 11% 3 11% 4 29% 5 47%

7. Brain at 17

1_____ 2 14% 3 31% 4 31% 5 22%

8. Methods and materials in Rochester Drug Education Classes.

1_____ 2 5% 3 14% 4 41% 5 38%

9. Methods and materials for Drug Education from Temple University Group.

1_____ 2 2% 3 2% 4 11% 5 85%

Please answer the following as honestly as possible. Check or fill in answer.

10. The topic was appropriate.

Yes 100% No_____

11. The meeting place was adequate.

Yes 100% No_____

12. Were you stimulated to do something.

Yes 98% No 1%

13. I would recommend others I know to attend a similar Institute.

Yes 100% No_____

14. I would attend other institutes like this one on different topics.

Yes 100% No_____

15. Assuming a yes answer to question 14, what topics would you like to see presented in an institute next year. In order of preference please.

1 SEX AND THE HANDICAPPED
2 WORKING WITH PARENTS OF HANDICAPPED
3 AREAS OF LEARNING DISABILITIES
4 VOCATIONAL EDUCATION
5 MANY OTHERS

Other Comments:

SEE ATTACHED PAGE —

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